PRINTED:	04/18/2022
FORM API	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES	
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OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155338 B. WING		<u></u>	(X3) DATE SU COMPLE' 03/28/2	ГED		
	PROVIDER OR SUPPLIEF			445 S (address, city, state, zip cod COUNTY ROAD 525 E IN 46123		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000							Diffe
Bldg		paredness Survey was ndiana Department of Health in CFR 483.73.	E 000)0	Majestic Care of Avon Respectfully requests a desk review/paper compliance		
	Survey Date: 03/28	8/22					
	Facility Number: 0 Provider Number: AIM Number: 100	155338					
	Care of Avon was f compliance with En Requirements for M	Preparedness survey, Majestic found in substantial mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR					
	The facility has 140 the survey, the cens) certified beds. At the time of sus was 97.					
	Quality Review cor	npleted on 03/30/22					
E 0039 SS=C Bldg	441.184(d)(2), 48 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4 §460.84(d)(2), §4 §483.475(d)(2), §4	18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					
	OPO, "Organizati	16.54, CORFs at §485.68, ons" under §485.727, 020, RHCs/FQHCs at					

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

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		IES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING 155338 B. WING				COMPLETED 03/28/2022	
	PROVIDER OR SUPPLIE			445 S C	ADDRESS, CITY, STATE, ZIP CO COUNTY ROAD 525 E IN 46123	DD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH	OULD BE	COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PPROPRIATE	DATE
	§491.12, and ES	RD Facilities at §494.62]:					
	exercises to test annually. The [fa following: (i) Participate in a community-base (A) When a com not accessible, c functional exercis (B) If the [fa natural or man-m activation of the is exempt from e community-base functional exercis actual event. (ii) Conduct an a every 2 years, op or functional exerci- (i) of this section include, but is no (A) A second full	[facility] must conduct the emergency plan cility] must do all of the a full-scale exercise that is d every 2 years; or munity-based exercise is onduct a facility-based se every 2 years; or cility] experiences an actual hade emergency that requires emergency plan, the [facility] ingaging in its next required d or individual, facility-based se following the onset of the conducted, that may t limited to the following: -scale exercise that is d or individual, facility-based					
	functional exercis (B) A mock disas (C) A tabletop ex	se; or					
	discussion using clinically-relevan set of problem st	•					
	to challenge an e (iii) Analyze the [maintain docume exercises, and en						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 03/28/2022 155338 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 445 S COUNTY ROAD 525 E MAJESTIC CARE OF AVON AVON. IN 46123 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill: or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise W4L721 Event ID: Facility ID: 000231 Page 3 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

AND PLAN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155338		A. BUILDING B. WING	ONSTRUCTION	03/	te survey Mpleted 28/2022
	PROVIDER OR SUPPLI		445 S (ADDRESS, CITY, STATE, ZIP (COUNTY ROAD 525 E IN 46123	COD	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	accessible, com facility-based fu (B) If the hospic man-made eme of the emergence exempt from en full-scale comm functional exerce emergency even (ii) Conduct an that may include following: (A) A second fu community-base functional exerce (B) A mock disa (C) A tabletop of facilitator that in using a narrated emergency scen statements, dire questions desig emergency plan (iii) Analyze the maintain docum exercises, and of the hospice's er *[For PRFTs at §482.15(d), CAI (2) Testing. The conduct exercis plan twice per y CAH] must do th (i) Participate in that is communi	munity-based exercise is not duct an annual individual inctional exercise; or e experiences a natural or rgency that requires activation cy plan, the hospice is gaging in its next required unity based or facility-based ise following the onset of the nt. additional annual exercise e, but is not limited to the all-scale exercise that is ed or a facility based ise; or aster drill; or exercise or workshop led by a cludes a group discussion d, clinically-relevant hario, and a set of problem cted messages, or prepared ned to challenge an thospice's response to and entation of all drills, tabletop emergency events and revise nergency plan, as needed. §441.184(d), Hospitals at ths at §485.625(d):] [PRTF, Hospital, CAH] must es to test the emergency ear. The [PRTF, Hospital, ne following: a n annual full-scale exercise				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 03/28/2022 155338 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 445 S COUNTY ROAD 525 E MAJESTIC CARE OF AVON AVON. IN 46123 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, W4L721 Event ID: Facility ID: 000231 Page 7 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155338	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/28/2022	
	PROVIDER OR SUPPLIE		445	et address, city, state, zip cod S COUNTY ROAD 525 E N, IN 46123		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETIO DATE	
	needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test RNHCI must do (i) Conduct a paper at least annually group discussion narrated, clinical scenario, and a se directed messag designed to chal (ii) Analyze the F maintain docume exercises, and e the RNHCI's emproper Based on record ref failed to conduct of plan at least twice unannounced staff procedures. The L following: (i) Participate in a is community-based a. When a community-based a. When a community-based b. If the LTC facillor or man-made emeric of the emergency from engaging its community-based full-scale function the onset of the act (ii) Conduct an addinclude, but is not a. A second full-scale	he RNHCI must conduct the emergency plan. The the following: ber-based, tabletop exercise . A tabletop exercise is a held by a facilitator, using a ly-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. RNHCI's response to and entation of all tabletop mergency events, and revise ergency plan, as needed. eview and interview, the facility exercises to test the emergency per year, including drills using the emergency TC facility must do the n annual full-scale exercise that ed; or nity-based exercise is not et an annual individual, stional exercise. ity experiences an actual natural rgency that requires activation plan, the LTC facility is exempt next required full-scale or individual, facility-based al exercise for 1 year following	E 0039	 What corrective action will be accomplished for tho residents found to have bee affected by the deficient practice. Corrected actions includ conducting internal tabletop exercise. How other residents having the potential to be affected by the same deficie practice will be identified an what corrective action(s) will be taken No residents can be affected. What measures will be put into place and what systemic changes will be mat to ensure that the deficient practice does not recur. Education provided to 	se n le nt d I	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155338	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/28/2022	
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD S COUNTY ROAD 525 E)	
MAJEST	TIC CARE OF AVO	Ν		N, IN 46123		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPL	LD BE ROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	functional exercise			Maintance Director on re	•	
	b. A mock disaster			of 2 tabletop exercises pe	•	
	-	cise or workshop that is led by a		internal 1 external. The ta	abletop	
		udes a group discussion, using		exercise will be added to	the	
		ly relevant emergency scenario,		facility TELS system to a	ert when	
	-	m statements, directed		this requirement is needing	ng	
		ared questions designed to		completed.		
	challenge an emerg	gency plan.		4. How the corrective)	
mair exer LTC acco	(iii) Analyze the L	TC facility's response to and		action(s) will be monitor	red to	
	maintain documen	tation of all drills, tabletop		ensure the deficient pra	ctice	
	exercises, and eme	ergency events, and revise the		will not recur, i.e., what	quality	
	LTC facility's eme	ergency plan, as needed in		assurance program will		
	-	2 CFR 483.73(d)(2). This		into place.	•	
		could affect all occupants.		a. The Maintance Dire	ector and	
	1	1		Executive Director will me		
	Findings include:			quarterly to ensure the de		
	8			practice does not reoccui		
	Based on record re	eview of the facilities Emergency			•	
		er entitled "Emergency				
	-	with the Maintenance Director				
	-	36 p.m., there was no				
		a second full-scale exercise that				
		ed or an individual,				
		tional exercise, a mock disaster				
		exercise or workshop that is led				
	, I	t includes a group discussion,				
		linically relevant emergency				
	-	of problem statements,				
		or prepared questions				
	-	nge an emergency plan. Based				
	-	the time of record review, the				
		ctor stated that the facility had				
		of the aforementioned				
		in the documented tornado drill				
		21. During the exit conference				
		-				
		aintenance Director and the $r = 0.2/28/22$ at 2:55 n m = no				
		r on 03/28/22 at 2:55 p.m., no				
		tion or evidence could be				
	provided contrary	to this deficient finding.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155338			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 03/28/2022	
	PROVIDER OR SUPPLI			445 S (ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 525 E IN 46123		
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< 0000							
Bldg. 01	Licensure Survey	le Recertification and State was conducted by the Indiana alth in accordance with 42 CFR	K 0	000	Majestic Care of Avon Respectfully requests a desk review/paper compliance		
	Survey Date: 03/	28/22					
	Facility Number: Provider Number: AIM Number: 10	155338					
	Avon was found i Requirements for Medicare/Medica Life Safety from I National Fire Prot Life Safety Code Building 0101, th 0202, which cons	id, 42 CFR Subpart 483.90(a), Fire and the 2012 edition of the fection Association (NFPA) 101, (LSC), and 410 IAC 16.2. e original building, and Building isted of the Therapy Care Unit e surveyed using Chapter 19,					
	Type V (111) con sprinklered. The f with smoke detect areas open to the operated smoke d resident sleeping hard wired to the of 78 resident sleep	cility was determined to be of struction and was fully acility has a fire alarm system tion in the corridors and in all corridor. The facility has battery etectors installed in 63 of 78 rooms and has smoke detectors fire alarm system installed in 15 eping rooms. The facility has a and had a census of 97 at the time					
		e residents have customary klered and all areas providing					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155338			(X2) MULTIPLE C A. BUILDING B. WING	<u>01</u>	3) DATE SURVEY COMPLETED 03/28/2022
	PROVIDER OR SUPPLI		445 S	ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 525 E , IN 46123	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY (facility services w Quality Review c	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION vere sprinklered.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	discharges, exit in accordance w of egress is cont all obstructions t emergency, unlet through 18/19.2. 18.2.1, 19.2.1, 7 Based on observa facility failed to n from obstructions facility. LSC 19.2 required width shi equipment, provid conditions are me (a) The wheeled e clear unobstructed in. (1525 mm.) (b) The health car training program wheeled equipme emergency. (c) The wheeled e following: i. Equipment in us ii. Medical emerg iii. Patient lift and This deficient pra 18 residents, 2 sta Findings include:	s - General ways, corridors, exit locations, and accesses are ith Chapter 7, and the means inuously maintained free of o full use in case of ess modified by 18/19.2.2 11. .1.10.1 tion and staff interview, the naintain the means of egress free in 1 of 8 corridors within the .3.4(4) states, projections into the all be permitted for wheeled ded that all of the following t: equipment does not reduce the d corridor width to less than 60 e occupancy fire safety plan and address the relocation of the nt during a fire or similar equipment is limited to the se and carts in use ency equipment citice could affect approximately	К 0211	 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. a. All isolation carts will be properly wheeled in the corridor. 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 No residents are affected by this deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Education provided to staff about the need to have items in corridors on wheels. 	Dy B

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DAT	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>01</u>	COM	PLETED
		155338	B. WING		03/28/2022	
NAME OF		n	ST	REET ADDRESS, CITY, STATE, ZIP C	COD	
	PROVIDER OR SUPPLIE			5 S COUNTY ROAD 525 E		
MAJEST	IC CARE OF AVO	N	A۱	/ON, IN 46123		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE A	HOULD BE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA			DATE
	Maintenance Direc	ctor on 03/28/22 during a tour of		ensure the deficient p	oractice	
	-	2:58 p.m. to 2:50 p.m. during a		will not recur, i.e., wh	at quality	
	tour the facility, th	e following was noted:		assurance program w	/ill be put	
	a) there was a sma	ll three drawer contact isolation		into place.		
	cart being stored in	n the corridor immediately		a. The Maintenance	e Director or	
	outside resident ro	om #602. It was noted that this		designee will monitor 5	5 times daily	
	small cart was not	on wheels.		x 4 weeks, weekly x 2	months	
	b) there was a port	able cart approximately 36		and monthly for 4 mon	ths.	
	inches high by 26	inches wide made of PVC pipe		Information will be revi	ewed in	
	immediately outsid	le resident room #608. This cart		QAPI, and all negative	outcomes	
	contained a 30-gal	lon igloo cooler, plastic cups,		will be corrected.		
	and two empty wa	ter pitchers. This cart was not				
	currently in use.	-				
	Based on interview	v at the time of the observation,				
	the Maintenance D	Director stated that he thought				
		e allowed to be left in the				
	corridor as long as	they were all kept on the same				
		uring the exit conference with				
		nance Director and the				
	Executive Director	on 03/28/22 at 2:55 p.m., no				
		tion or evidence could be				
	provided contrary	to this deficient finding.				
	3.1-19(b)					
(0321	NFPA 101					
SS=E	Hazardous Areas	s - Enclosure				
Bldg. 01	Hazardous Areas					
=		are protected by a fire				
		nour fire resistance rating				
	-	e rated doors) or an				
	`	inguishing system in				
		8.7.1 or 19.3.5.9. When the				
		atic fire extinguishing system				
		e areas shall be separated				
		s by smoke resisting				
		ors in accordance with 8.4.				
	Doors shall be se					
		g and permitted to have				
		applied protective plates that				
	I normation of norm-	Service procours places that	1			1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155338	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 03/28/2022	
	PROVIDER OR SUPPLIE		445 S	f address, city, state, zip cod COUNTY ROAD 525 E J, IN 46123		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
	the door. Describe the floo hazardous areas REMARKS. 19.3.2.1, 19.3.5.4 Area Separation a. Boiler and Fue b. Laundries (larg c. Repair, Mainte d. Soiled Linen F gallons) e. Trash Collectio (exceeding 64 ga f. Combustible S (over 50 square f g. Laboratories (i Hazard - see K32 Based on observat failed to ensure the hazardous areas, s rooms over 50 squ boiler rooms, were devices which woo automatically clos frames or provided partitions. This de residents, 3 staff a Findings include: Based on observat Maintenance Direc the facility from 1 tour the facility, th a) the Private dinin	Automatic Sprinkler N/A el-Fired Heater Rooms ger than 100 square feet) enance, and Paint Shops Rooms (exceeding 64 on Rooms allons) torage Rooms/Spaces feet) if classified as Severe 22) ion and interview, the facility e corridor door to 1 of 10 uch as combustible storage tare feet, soiled linen rooms, and e provided with self-closing uld cause the doors to e and fully latch into the door d with smoke resistant ficient practice could affect 18	K 0321	K 321 (E) Hazardous Areas 1. What corrective action(s) will the accomplished for those residents found to have been affected by the deficient practice. a. The Dining room and Doctors office was clean out removing and items that would be considered combustible 2. 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 a. No residents have the potentiat to be affected by this deficient practice.	s he IY e	

	R MEDICARE & MEDI				OMB NO. 0938	8-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155338	(X2) MULTIPLE C A. BUILDING B. WING	0NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/28/2022	
	PROVIDER OR SUPPLIE		445 S (ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 525 E IN 46123		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X: COMPLE	
TAG	cloth covered chain boxes of supplies, bags of miscellane b) the Doctors offi converted into a fa had numerous card items. Both aforemention 100 square feet in device on the door was verified by the stated that they we delivered shortly a above mentioned r delivered and read conference with th and the Executive	R LSC IDENTIFYING INFORMATION rs, numerous miscellaneous and six 50-gallon clear trash ous clothing items. ce room had recently been cility storage room. This room board boxes of miscellaneous ed rooms measured well over size and lacked a self-closing leading to the corridor. This Maintenance Director who re having a storage shed nd that he would clean both pooms out as soon as it was y for use. During the exit e facility Maintenance Director Director on 03/28/22 at 2:55 information or evidence could	TAG	place and what systemic char will be made to ensure that the deficient practice does not rea a. Education for the Maintance Director provided on keeping rooms/areas clear/Uncluttere Self-closing devices have bee added to affected locations. 4. How the corrective action(s be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place a. The Maintance Director or Designee will monitor the dini room and doctors' office to en they are free from excess combustible material 5 days a	ne cur. ce d. en s) will ur, e. ing nsure	E
K 0345 SS=C Bldg. 01	be provided contra 3.1-19(b) NFPA 101 Fire Alarm System Maintenance Fire Alarm System			week x 4 weeks, weekly x 2 months and monthly x 4 mon	ths.	
	in accordance wi complying with th National Electric National Fire Alar Records of syste and testing are re 9.6.1.3, 9.6.1.5, N Based on observat failed to maintain	m is tested and maintained th an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. m acceptance, maintenance eadily available. NFPA 70, NFPA 72 on and interview, the facility he fire alarm system to assure time and date information in	K 0345	K345 (C) Fire Alarm System		/202
	accordance with th	e requirements of NFPA 101- ons 19.3.4 and 9.6 and NFPA 72		 What corrective action will be accomplished for the residents found to have bee 	ose	

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155338	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMI	MB NO. 0938-039 E SURVEY PLETED 8/2022
AND PLAN			A. BUILDING B. WING STREET 445 S	B. WING OC STREET ADDRESS, CITY, STATE, ZIP COD 445 S COUNTY ROAD 525 E AVON, IN 46123 ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Affected by the deficient practice. affected by the deficient practice. a. The fire panel has been corrected with accurate time and date. 2. 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 a. no resident has the potential to be affected by this deficient practice. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. Education provided to		PLETED
(0351 SS=E Bldg. 01	contrary to this def 3.1-19(b) NFPA 101 Sprinkler System Spinkler System	- Installation		Maintance Director on rec of NFPA 101-2021 edition 4. How the corrective action(s) will be monitor ensure the deficient prace will not recur, i.e., what c assurance program will l into place. a. The Maintenance Di designee will monitor the for time and date accurac a week x 4 weeks, weekly months and monthly x 4 m All items will be reviewed and any negative trends v reviewed and corrected.	ed to stice quality be put irector or fire panel y 5 days y 5 days y x 2 nonths. in QAPI,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/28/2022 155338 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 445 S COUNTY ROAD 525 E MAJESTIC CARE OF AVON AVON. IN 46123 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) K 0351 04/12/2022 Based on observation and interview, the facility What corrective action(s) 1. failed to ensure the spray pattern for sprinkler will be accomplished for those heads were not obstructed in 1 of 1 freezer and 1 residents found to have been of 1 walk-in cooler in accordance with LSC affected by the deficient 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 practice. states sprinklers shall be located so as to minimize The corrective actions will a. obstructions to discharge as defined in Section include relocating sprinkler and 8.5.5.2 and Section 8.5.5.3 or additional sprinklers adding an additional sprinkler to shall be provided to ensure adequate coverage of both 1 of 1 locations referenced in the hazard. Sections 8.5.5.2 and 8.5.5.3 do not the 2567. permit continuous or noncontinuous obstructions How other residents 2 less than or equal to 18 inches below the sprinkler having the potential to be deflector or in a horizontal plane more than 18 affected by the same deficient inches below the sprinkler deflector that prevent practice will be identified and the spray pattern from fully developing. This what corrective action(s) will deficient practice could affect as many as 5 staff. be taken No residents have the a. Findings include: potential to be affected. 3 What measures will be W4L721 Event ID: Facility ID: 000231 Page 18 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

04/18/2022

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NTERS FO	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155338		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 03/28/2022		
	PROVIDER OR SUPPLIEF		445 S (ADDRESS, CITY, STATE, ZIP COD COUNTY ROAD 525 E IN 46123		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	COMPLETION DATE
	facility with the Ma at 12:49 p.m., The s kitchen freezer was the compressor and spray pattern of the Furthermore, the sp kitchen walk-in-coo inches from the cor obstruct the spray p event of a fire. Bass observation, the Ma acknowledged the r agreed the compres sprinkler spray patt with the facility Ma Executive Director additional informat	on made during a tour of the intenance Director on 03/29/22 sprinkler head located within the approximately two inches from would definitely obstruct the sprinkler in the event of a fire. rinkler head located within the oler was also approximately two npressor and would definitely attern of the sprinkler in the ed on interview at the time of intenance Director measurements given and sors would obstruct the ern. During the exit conference intenance Director and the on 03/28/22 at 2:55 p.m., no ion or evidence could be o this deficient finding.		 put into place and what systemic changes will be into ensure that the deficient practice does not recur. a. Relocating sprinkler h from ceiling to the side of the freezer and Refrigerator will that the spray pattern will be to cover the entire area. 4. How the corrective action(s) will be monitored ensure the deficient practive will not recur, i.e., what quassurance program will be into place. a. The Maintance Direct designee will monitor month months to ensure new equia and the locations are function 	t eads le lensure e able d to ice lality e put tor or nly x 4 pment	

W4L721 Facility ID: 000231

231 If continuation sheet

ation sheet Page 19 of 19