STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155338	A. BUILDING -- B. WING	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF AVON	445 S COUNTY ROAD 525 E AVON, IN 46123

(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: 07/17/23 Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900 At this Emergency Preparedness survey, Majestic Care of Avon was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 140 certified beds. At the time of the survey, the census was 92. Quality Review completed on 07/19/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/17/23 Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900 At this Life Safety Code survey, Majestic Care of Avon was found not in compliance with	K 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during a Life Safety Survey with exit on 07/17/23. Please accept this Plan of Correction as the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Josiah Marx	Executive Director	08/04/2023

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.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. Building 0101, the original building, and Building 0202, which consisted of the Therapy Care Unit (TCU) wing, were surveyed using Chapter 19, Existing Health Care Occupancies. 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 and in all areas open to the corridor. The facility has battery operated smoke detectors installed in 63 of 78 resident sleeping rooms and has smoke detectors hard wired to the fire alarm system installed in 15 of 78 resident sleeping rooms. The facility has a capacity of 140 and had a census of 92 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/19/23		provider's credible allegation of compliance as of August 17, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
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			

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	* 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			
	1) Based on observation and interview, the facility failed ensure 1 of 1 kitchen hood extinguishing system provided complete coverage for equipment that produces grease-laden vapors. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. This deficient practice could affect 18 residents, 6 staff, and 4 visitors. Findings include: Based on observation with the facility and Administrator on 07/17/23 at 2:02 p.m., the kitchen was provided with a UL 300 hood system but the nozzles were not properly aligned as to completely cover the stove-top, the griddle, and the deep fryer. Based on interview at the time of observation, the facility Administrator agreed that the alignment of the UL 300 hood system nozzles were not aligned as to provide complete coverage of the cooking areas on the stovetop. This finding was reviewed with the Administrator during the exit conference on 07/17/23 at 2:15 p.m.	K 0324	It is the responsibility of this facility to ensure that the range hood extinguishing system is maintained and in proper working condition. **The corrective action taken for those residents found to be affected by the deficient practice includes:** There are no identified residents. **How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action will be taken.** All residents have the potential to be affected but none were identified. The nozzles were realigned with the cooking equipment and are correctly positioned. Paperwork was found where semiannual inspection completed. Noted exhaust wasn't working at time of completion but has been since remedied.	08/17/2023

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	3.1-19(b) 2) Based on record review, observation, and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect as many as 18 residents, 6 staff, and 4 visitors. Findings include:		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The nozzles of the range hood extinguishing system were realigned with the cooking equipment and are correctly positioned. The semi-annual hood inspection was completed on **3-27-23 see attached** **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The maintenance director and/or his designee will audit range hood system 1x weekly x3 months and then 1 x monthly for 3 months any negative findings will be immediately remedied, and ED informed. The semi annual hood inspection has been added to TELS for future completion and audit control. All findings will be brought to the QA meeting. Administrator to monitor.	

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	Based on record review on 07/17/23 at 11:34 a.m. with the facility Administrator, documentation of semiannual kitchen exhaust system inspections for the last twelve months was not available for review. The kitchen exhaust system inspection documentation that could be located was competed by the facility vendor on 03/27/23, but no other documentation could be located as of the time of this survey. The lack of semiannual overhead kitchen exhaust system inspections was verified by the facility Administrator at the time of record review. This finding was reviewed with the Administrator during the exit conference on 07/17/23 at 2:15 p.m. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			
	1) Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff, and visitors in the facility.	K 0712	**It is the responsibility of this facility to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions.** The corrective action taken for those residents found to be	08/04/2023

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	Findings include: Based on record review on 07/17/23 at 10:05 a.m. with the facility Administrator, documentation could not be provided regarding a fire drill for the second quarter (April, May, or June) of 2023. Based on interview at the time of record review, the facility Administrator acknowledged that there was no additional available fire drill documentation available for review at the time of this survey. This finding was reviewed with the Administrator during the exit conference on 07/17/23 at 2:15 p.m. 3.1-19(b) 3.1-51(c) 2) Based on record review and interview, the facility failed to ensure 4 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff, and visitors. Findings include: Based on record review of the document titled "Disaster / Fire Drill Record" with the facility Administrator on 07/17/23 at 10:06 a.m., the documentation for the drills conducted on the night shift lacked verification of the transmission of the fire alarm signal with the monitoring station. Based on interview at the time of record review, the facility Administrator agreed that the night shift fire drills lacked verification of the transmission of the signal with the monitoring		affected by the deficient practice inlclude: There are no identified residents. How other residents that have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. A fire drill was conducted on 8/2/23. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director was in serviced regarding fire drills must be held every month on staggering dates and times throughout the month. Every quarter a drill must be conducted on each shift. Drills that occur on the night shift with a silent alarm must be reviewed and alarm sounding the following day. Transmission of a fire alarm signal and simulation of emergency fire conditions must occur and will be documented on fire drill paperwork. How the corrective action will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: The maintenance director and/or his designee will conduct monthly fire drills that are on different shifts	

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	station and added that he would discuss this with the Maintenance man as soon as he returned. This finding was reviewed with the Administrator during the exit conference on 07/17/23 at 2:15 p.m. 3.1-19(b) 3.1-51(c)		and staggered through a 24-hour period so they all don't fall at the same time on the same shift. Fire drill paperwork will be completed in its entirety. Documentation of the transmission of signal and outcome of simulation. Drills will be brought to the quarterly QA for review and signed by attendees. Administrator to monitor. ="" p=""> ="" bthere="" are="" no="" identified="" residents <="" p=""> ="" p=""> ="" ball="" but="" none="" were="" identified. ="" a="" fire="" drill="" was="" conducted="" on="" 8="" 02="" 23 ="" <="" p=""> ="" b ="" ="" maintenance="" director="" was="" inserviced="" fire="" drills="" must="" held="" every="" month="" on="" staggering="" dates="" times="" throughout="" month. ="" quarter="" a="" drill="" conducted="" each="" shift.="" occur="" night="" shift="" with="" silent="" alarm="" reviewed="" sounding="" following="" day. ="" transmission="" of="" signal="" simulation="" emergency="" conditions="" documented="" paperwork. <="" p=""> ="" p=""> ="" b=""> ="" p=""> ="" p="" <=""> ="" p="">	

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to			

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	avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 12 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect as many as 18 residents, 6 staff, and 4 visitors. Findings include: Based on observation with the facility and Administrator on 07/17/23 at 1:30 p.m., on 09/25/17, one small green portable oxygen cylinder was standing upright on the floor of the oxygen storage and transfilling room and was not properly chained or supported in a cylinder stand or cart. Based on interview at the time of observation, the facility Administrator acknowledged the oxygen cylinder was standing upright on the floor of the oxygen storage and transfilling room and was not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Administrator during the exit conference on 07/17/23 at 2:15 p.m. 3.1-19(b)	K 0923	**It is the responsibility of this facility to ensure that oxygen cylinders are proper secured from falling.** **The corrective action taken for those residents found to be affected by the deficient practice includes:** No residents were identified. How other residents that have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be affected but none were identified. The green oxygen tank was properly secured, and audit tool was implemented. All staff in serviced on proper o2 storage. 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 in serviced on this deficient practice. The green o2 tank was properly secured and audit tool implemented. How the corrective action will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: The maintenance director and /or his designee will conduct weekly	08/02/2023

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			audits of the oxygen room and free-standing cylinders for 3 months and then monthly for 3 months. All deficient practices will be immediately remedied, and results brought to the attention of the ED. Audit results will be shared with the monthly QAPI team.	