STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING -- B. WING	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(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: 07/18/22 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Emergency Preparedness survey, Majestic Care of Connersville was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 166 certified beds. At the time of the survey, the census was 99. Quality Review completed on 07/28/22	E 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** /b>	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

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

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	155491	A. BUILDING -- B. WING	07/18/2022

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	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of 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 a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least 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 individual, 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. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[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			

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	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 hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or 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 a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] 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			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, 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. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization 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 PACE experiences an actual natural			

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	or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based 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 individual, 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. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, 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. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that			

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	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,			

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	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 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. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

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	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 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 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. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise 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. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility 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. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional 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	E 0039	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected. The facility conducted a full scale exercise and exercise of choice. Both were completed no later than 8-10-2022. 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. 1. All residents have the potential to be affected by the alleged deficient practice. The facility conducted a full scale exercise and exercise of choice.	08/10/2022

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	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that 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's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the Emergency Operations Plan and interview with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 11:00 a.m. and 2:15 p.m., the facility lacked documentation of an actual emergency; a required (1) full-scale exercise; and a (2) second exercise of choice during the past year. Based on interview at the time of record review, the Executive Director commented that they "simply didn't have the drills." The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present.		Both were completed no later than 8-5-2022. On 7-19-2022 the facility Administrator educated the Maintenance Director regarding the regulation of having a full scale exercise and exercise of choice completed every 12 months. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The facility Maintenance Director/designee will conduct both a full scale exercise and exercise of choice yearly. A calendar will be kept by the Maintenance Director as to when both exercises will be completed by. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings yearly, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	

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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: 07/18/22 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Life Safety Code survey, Majestic Care of Connersville 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. The facility consisted of two, one story buildings, the East Building (2) and the West Building (1), which were determined to be of Type V (111) construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a capacity of 166 and had a census of 99 at the time of this survey.	K 0000	5. Date of Compliance: 8-10-2022 **The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** /b>	

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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 07/28/22			
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 8 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 46 residents. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., in the exit corridor near resident room 701 there was a bed protruding into the corridor about four feet. Based on an interview at the time of observations, the Maintenance Director stated the bed was in the corridor obstructing the exit and will be moved. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance	K 0211	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Residents on the 700 Unit have the potential to be affected. The bed was removed on 7-18-2022. 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. 1. All Residents have the potential to be affected by this alleged deficient practice. 2. A campus wide review was completed to ensure no other beds or obstructions were present in any hall or unit in both the East	08/10/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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	Director present. 3.1-19(b)		and West buildings. 3. The Maintenance Director was educated on the regulation of keeping hallways and egresses free of obstructions. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The facility Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure hallways and common areas are free of obstructions. **4.** 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance:	

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			8-10-2022	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 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			

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	upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted 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 8 of over 10 means of egress 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 over 15, staff and visitors if	K 0222	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents and visitors have the potential to be affected. All common exit doors were equipped with a labeled instruction of how to enter a numbered code to exit the facility. Door codes to be placed at each common exit	08/10/2022

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	needing to exit the facility. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the following exit doors, marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exits or an inaccurate code was posted. A) The front door main entrance/exit (West Building) (inaccurate code). B) Facility Exit door near the Activities Director office (not posted). C) Facility Exit doors from the Therapy Area (code not posted and believed code not working. The Administrator in Training commented "none of the known codes are working." D) 900 Hall corridor exit door (code not posted). E) Main Entrance (East Building) (code not posted). F) Exit between the 200 and 300 hall in East building (not posted). G) 200 Hall exit door (not posted). H) The Gate outside the 200 Hall Exit (code not posted). The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		door by 8-10-2022. 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. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure all common exit doors had a label with instructions on how to exit the facility. 3. Maintenance Director was educated on the regulation of ensuring labels are posted at all common exit doors for exiting the facility. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The facility Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure common exit doors have a label with instructions on how to exit the facility.	

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			4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview the facility failed to provide lighting under normal power along the paths of egress in accordance with the requirements of NFPA 101 - 2012 edition, sections 19.2.8 and 7.8. This deficient practice could affect	K 0281	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	08/10/2022

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	all 10 residents residing at the facility at the time of the survey, as well as an indeterminable number of staff and visitors. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the exit discharge sidewalks from the Southwest exit from the West Building did not have egress lighting for portions of the sidewalks from the exit to the public way. Based on interview at the time of observations, the Administrator in Training and Executive Director confirmed there were no other lighting devices illuminating the sidewalks, and stated it was undetermined if all of the aforementioned exit paths were provided with any other egress lighting. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		1. Residents and visitors exiting the Southwest exit from the West building on the 900 hall have the potential to be affected. The facility Maintenance Director installed lighting at that exit to light the sidewalk for easy exit from the facility. 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. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure appropriate lighting of all egress areas of the facility. 3. Maintenance Director was educated on the regulation of ensuring all egress areas of the facility are properly illuminated. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the	

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			East and West buildings to ensure all egress areas are properly illuminated. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1) Based on observation and interview, the facility failed to ensure 1 of 5 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for	K 0291	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Residents and visitors exiting the Southwest exit from	08/10/2022

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	maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the 600-700 hall corridor battery-operated emergency light failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned battery-operated emergency light failed to function when its respective test button was pushed. Furthermore, the EXIT signs located in the vicinity of and attached to the aforementioned light did not appear to be illuminated. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b) 2) Based on observation and interview the facility failed to provide emergency lighting along the paths of egress in accordance with the requirements of NFPA 101 - 2012 edition, sections 19.2.8 and 7.8. This deficient practice could affect		the West building on the 900 hall have the potential to be affected. The facility Maintenance Director installed lighting at that exit to light the sidewalk for easy exit from the facility. 2. EXIT lights and emergency lighting were fixed to properly illuminate the areas of concern. 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. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure egresses were properly illuminated and all facility EXIT signs and emergency lighting work properly. 3. Maintenance Director was educated on the regulation of ensuring all egress areas of the facility are properly illuminated and all facility EXIT signs and emergency lighting work properly. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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	all 10 residents residing at the facility at the time of the survey, as well as an indeterminable number of staff and visitors. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the exit discharge sidewalks from the Southwest exit from the West Building did not have emergency lighting for portions of the sidewalks from the exit to the public way. Based on interview at the time of observations, the Administrator in Training and Executive Director confirmed there were no other lighting devices illuminating the sidewalks, and stated it was undetermined if the aforementioned exit paths were provided with emergency lighting. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		1. The Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure all egress areas are properly illuminated and all EXIT signs and emergency lighting work properly. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the			

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	approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 3 staff and visitors. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., The (1) Activities Director office, greater than 50 square	K 0321	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. The Activities Director Office and Bio-hazard Room on the 300 Unit had self-closing devices installed on the doors. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/10/2022

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	feet, contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The corridor door to this office was not provided with a self-closing device. Furthermore, (2) the Bio-Hazard room across from resident room 317 contained medical waste and combustible materials and was not equipped with a self-closing device. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure all Hazardous areas needing a self-closing device had one installed. 3. Maintenance Director was educated on the regulation of ensuring all necessary doors with Hazardous areas had a self-closing device installed and working properly. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure all Hazardous areas has working self-closing devices installed and working properly. 4. 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.	

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			1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
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.			

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	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 to ensure 1 of 1 kitchen range hood extinguishing systems was maintained in proper working order. 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. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. This deficient practice was not in a resident area but could affect 6 kitchen staff. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the kitchen range hood extinguishing system nozzles were not properly positioned over the cooking equipment under the hood. All nozzles were pointed and oriented in locations which were not over actual appliances. The Maintenance Director confirmed the nozzles did not appear to be positioned over the cooking equipment at the time of this survey. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure staff were instructed in the use of	K 0324	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. The facility dietary employees were re-educated on how to extinguish Grease Fires in the kitchen. Also, the Maintenance Director realigned the range hood extinguishing system nozzles over the cooking equipment. 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. 1. All Residents have the potential to be affected by this practice. 2. The facility dietary employees were re-educated on how to extinguish Grease Fires in the kitchen. Also, the Maintenance Director realigned the range hood extinguishing system nozzles over the cooking equipment. 3. Maintenance Director was educated on the regulation of ensuring dietary staff are educated regarding extinguishing grease	08/10/2022

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	155491	A. BUILDING 01 B. WING	07/18/2022

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	the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect 6 staff in the kitchen and 25 residents in the dining room. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the kitchen in the West building contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Evening Cook at the appliance was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied, "Grab an extinguisher." When asked, "do you know when to use your hood suppression pull station?" The employee replied. "that's for a fire anywhere in the kitchen." The Executive Director acknowledged the responses and stated additional training would be necessary. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		fires and also ensuring that the range hood extinguishing system nozzles are positioned over the cooking equipment. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure that the range hood extinguishing system nozzles are over the cooking equipment. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	

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K 0346 SS=F 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 record review and interview with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 11:00 a.m. and 2:15 p.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH 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 Executive Director acknowledged the fire watch documentation provided stated to contact the Indiana State	K 0346	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. The Administrator amended the Fire Watch Plan to include contacting ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method if ISDH Gateway is non-operational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov. 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.	08/10/2022

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	Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		1. All Residents have the potential to be affected by this practice. 2. The facility Administrator educated the Maintenance Director and Administrator-In-Training on the regulation of properly reporting incidents as follows: contacting ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method if ISDH Gateway is non-operational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Administrator will audit annually the proper documentation of reporting incidents as follows: contacting ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method if ISDH Gateway is non-operational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov. 4. How the corrective	

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			action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the Administrator/designee will review any findings yearly, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0354 SS=F 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)			

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	Based on record review and interview, the facility failed to provide 1 of 1 correct written policy 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 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 record review and interview with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 11:00 a.m. and 2:15 p.m., the fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH 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 Executive Director acknowledged the fire watch documentation provided stated to contact the Indiana State	K 0354	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. residents have the potential to be affected by the alleged deficient practice. The Administrator amended the Fire Watch Plan to include contacting ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method if ISDH Gateway is non-operational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov 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. 1. All Residents have the potential to be affected by this practice. 2. The facility Administrator educated the Maintenance Director and Administrator-In-Training on the regulation of properly reporting incidents as follows: contacting ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method if ISDH Gateway is non-operational by completing the Incident Reporting	08/10/2022

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	Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		form and emailing it to incidents@isdh.in.gov. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Administrator will audit annually the proper documentation of reporting incidents as follows: contacting ISDH via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method if ISDH Gateway is non-operational by completing the Incident Reporting form and emailing it to incidents@isdh.in.gov. 4. 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. 1. For quality assurance, the Administrator/designee will review any findings yearly, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	

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			5. Date of Compliance: 8-10-2022	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect all portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was	K 0355	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. All facility fire extinguishers are up to date with monthly inspections. 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. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure that all facility fire extinguishers are up to date with monthly inspections. 3. The Maintenance Director was educated on the regulation of	08/10/2022

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	performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 6 staff in the lounge. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the monthly inspection tag on the ABC fire extinguisher located in the Staff Lounge lacked documentation of recent monthly inspections since 4/22. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		ensuring all fire extinguishers are inspected monthly. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will complete a 100% audit monthly for 3 months during his rounding of the East and West buildings to ensure that all fire extinguishers are inspected monthly. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 15 staff and 30 residents. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The double door set into the dining room in the West building. b) The storage room on the 700 hall - equipped with a self closing device. c) The storage room by dietary - equipped with a self closing device. d) The Kitchen door marked Dietary - equipped with a self closing device. e) The Laundry corridor door - equipped with a self closing device. f) The 600 hall storage closet - equipped with a self closing device. g) The unmarked resident room nearest the exit to the vent unit did not close and latch positively into its respective door frame. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present.	K 0363	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. The doors of concern during the survey have been readjusted and latch positively into their respective door frames. 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. 1. All Residents have the potential to be affected by the alleged deficient practice. 2. A campus wide audit was completed to ensure all facility doors latch positively into their respective door frames. 3. The Maintenance Director was educated on the regulation of having all facility doors latch positively into their respective door frames. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Maintenance	08/10/2022

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	3.1-19(b)		Director/designee will complete a 100% audit 2 times a week for 3 months during his rounding of the East and West buildings to ensure that all facility doors latch positively into their respective door frames. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.			

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	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes in the Riser room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 3 staff. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., an electrical junction box on the ceiling in the storage room next to the dietary office was not provided with a cover and had exposed electrical wiring hanging out of the box. The Maintenance Director stated he was unaware of what was going on with the junction box. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment	K 0511	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. The exposed wiring in the electrical junction box was fixed; the ice machine in the West kitchen had a GFCI installed; and all electrical panels have locks on them. 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. 1. All Residents with a PICC line have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure no exposed wiring was found in any electrical junction boxes and all electrical panels have locks on them. 3. Maintenance Director was educated on the regulation of not having exposed wiring in electrical junction boxes and having all electrical panels equipped with locks. In addition, education was provided regarding the necessity of having GFCI receptacles installed around water sources.	08/10/2022

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	155491	A. BUILDING 01 B. WING	07/18/2022

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	to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection.		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Maintenance Director/designee will complete a 100% audit 2 times a week for 3 months during his rounding of the East and West buildings to ensure no exposed wiring is present, GFCIs are appropriately placed and electrical panels are locked. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	

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	Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 staff near the ice machine. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the ice machine in the kitchen was connected to an electric receptacle which was being used to power the freestanding ice machine, with it's own water supply. The ice machine was located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). The Maintenance Director at the time of observation stated he did not believe the receptacle was on a GFCI circuit. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance			

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	Director present. 3. Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect 10 staff and 26 residents. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., 2 of 3 electrical panels in the 300 hall were unlocked when tested. Based on interview at the time of observation, the Administrator in Training stated the electrical panels were unlocked recently and will need to be relocked. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present.			

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K 0712 SS=F Bldg. 01	3.1-19(b) 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 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients. Findings include: Based on record review and interview with the Administrator in Training, Executive Director and	K 0712	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All facility residents have the potential to be affected by the alleged deficient practice. Moving forward from our Plan of Correction date the facility will be conducting fire drills per shift quarterly per regulation. 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. 1. All Residents have the potential to be affected by this practice. 2. Moving forward from our	08/10/2022

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	Maintenance Director on 07/18/22 between 11:00 a.m. and 2:15 p.m., the Second shift, second quarter fire drill documentation was missing and any documentation of completed orientation training for the above-mentioned quarter. Based on interview at the time of record review, the Executive Director agreed there was one missing fire drill and staff has not been trained in the fire safety procedures for the second quarter. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b) 3.1-51(c)		Plan of Correction date the facility will be conducting fire drills per shift quarterly per regulation. 3. The Maintenance Director was educated on the regulation of having a fire drill per shift per calendar quarter. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will complete an audit quarterly to ensure that the facility has fire drills conducted per regulation. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance:	

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K 0741 SS=F 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. (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 2 of 2 smoking areas and 1of 1 non-smoking areas were maintained by disposing cigarette butts in a metal or noncombustible	K 0741	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	08/10/2022

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	container with self-closing cover devices. This deficient practice could affect all residents. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., cigarette butts were observed and prevalent on the ground around the facility including but not limited to the following locations: a) Around the front entrance, where a no smoking sign was posted, there were over 10 cigarette butts disposed on the ground. A resident in a wheelchair was observed smoking, unsupervised, near the front entrance by this surveyor upon arrival. The identity of the resident was pointed out to the Executive Director during the facility tour. b) More than 10 butts outside the Activities Director Exit door. c) More than 75 butts outside the Kitchen Exit door. d) More than 100 butts outside the Memory Care 300 hall exit in the East building. The finding was reviewed with the Executive Director at the time of discovery who stated smoking was a problem at the facility, and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		1. All residents have the potential to be affected by the alleged deficient practice. All cigarette butts were appropriately disposed of in a metal or non-combustible container with a self-closing cover device. 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. 1. All Residents have the potential to be affected by the alleged deficient practice. All cigarette butts were appropriately disposed of in a metal or non-combustible container with a self-closing cover device. 2. A campus wide audit of the facility grounds was completed to eliminate all cigarette butts were properly disposed of. 3. The Maintenance Director was educated on the need to have all cigarette butts appropriately disposed of in a metal or non-combustible container with a self-closing cover device. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	

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			1. The Maintenance Director/designee will complete an audit 5 times a week for 3 months to ensure all cigarette butts were properly disposed of. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data.			

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	Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle	K 0914	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. All facility receptacles have tested. 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. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed of all facility receptacles and each receptacle was tested.	08/10/2022

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	(except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all 99 residents. Findings include: Based on record review and interview with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 11:00 a.m. and 2:15 p.m., an itemized listing of inspection and testing electrical outlet receptacles within the most recent twelve-month period was not available for review. Furthermore, no documentation of receptacle testing prior to January 2020 and the onset of the COVID-19 Pandemic were available for review. Based on observations with the Maintenance Director during a tour of the facility each resident room in the East and West buildings (with the exception of the Vent Unit in the East Building) contained multiple electrical receptacles installed near resident bed locations. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		3. The Maintenance Director was educated on the regulation of all facility receptacles to be tested and inspected within 12 months of the previous inspection/testing. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will inspect and test all facility receptacles within 12 months of the previous inspection/testing. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings yearly, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training,	K 0920	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. The rooms found to be of concern during the survey has had the power strips removed. Also, the multi-plug adapter in the laundry area was removed.	08/10/2022

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	Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., there was a power strip that was in use next to the resident's bed in room 702 that did not met 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use next to a resident bed and did not meet 1363A or 60601-1. 2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry room did not use multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 4 staff. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the Laundry room behind the washing machines contained a multi-plug adaptor powering equipment. Based on interview at the time of observation, the Maintenance Director agreed a mulita-plug adaptor was in use in the laundry area. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		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. 1. All Residents residing on the memory care unit have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure that only approved power strips are being used and no multi-plug adapters in the laundry areas. 3. The Maintenance Director was educated on the regulation of only approved power strips to be used in the facility and no multi-plug adapters in the laundry areas. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will audit weekly for the use of approved power strips in the facility. 4. 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	

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MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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			place. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0000 Bldg. 03	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: 07/18/22 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Life Safety Code survey, Majestic Care of Connersville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, and 410 IAC 16.2.	K 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** /b>	

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	The facility consisted of two, one story buildings, the East Building (2) and the West Building (1), which were determined to be of Type V (111) construction and fully sprinkled. Each building has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a capacity of 166 and had a census of 99 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 07/28/22			
K 0293 SS=E Bldg. 03	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 emergency Exit and directional sign was displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system and complies with section 19.2.10.1. Findings Include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on	K 0293	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. EXIT lights and emergency lighting were fixed to properly illuminate the areas of concern. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/10/2022

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	07/18/22 between 2:15 p.m. and 6:00 p.m., the 600-700 hall corridor battery-operated emergency light failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned battery-operated emergency light failed to function when its respective test button was pushed. The EXIT sign located in the vicinity and attached to the aforementioned light was also not illuminated. The Maintenance Director stated that the power to the lights might not be turned on at the utility breaker box. Because the Maintenance Director was new to the facility, he was unsure which breakers controlled the exit and emergency lights. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure all facility EXIT signs and emergency lighting work properly. 3. Maintenance Director was educated on the regulation of ensuring all EXIT lights and emergency lighting properly illuminate. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure all EXIT signs and emergency lighting work properly. 4. 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. 1. For quality assurance, the Maintenance Director/designee	

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			will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0361 SS=E Bldg. 03	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 alcoves with a large quantity of combustible mattresses open to the corridor was not used as hazardous storage. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff and 25 residents.	K 0361	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Residents on the 900 Hall have the potential to be affected by the alleged deficient practice. The wooden pallets and mattresses were removed on 7-19-2022. 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.	08/10/2022

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	Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., near Resident Room 907 3 beds and over 50 large cardboard boxes and two wooden pallets were protruding over 4 feet into the exit corridor obstructing the exit from the 900 hall and creating a hazardous area open to the corridor. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		1. All Residents with a catheter have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure all halls were unobstructed in the East and West Buildings. 3. The Maintenance Director was educated on the regulation of not having obstructed hallways in the East and West Buildings. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director/designee will complete a 100% audit 5 times a week for 3 months during his rounding of the East and West buildings to ensure that all hallways are not obstructed. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and	

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			education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0918 SS=F Bldg. 03	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			

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	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 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 observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1, requires the remote manual stop station to be labeled. Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the	K 0918	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. The facility installed the generator remote emergency stop on 8-2-2022 for the West facility generator. 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. 1. All Residents have the potential to be affected by this practice. 2. The facility installed the generator remote emergency stop on 8-2-2022 for the West facility generator. 3. Education was provided to the Maintenance Director of the regulation of having an emergency	08/10/2022

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	generator for the West building was not equipped with an emergency stop button which could be located. The Administrator in Training, Executive Director and Maintenance Director were not sure of the location of an emergency stop for the generator. A telephone call to a corporate maintenance professional did not assist in locating an emergency stop button. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)		remote stop for emergency generators. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Maintenance Director will ensure that the emergency generator has the emergency remote stop. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0923 SS=E Bldg. 03	NFPA 101 Gas Equipment - Cylinder and Container Storag			

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	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 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			

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	99) Based on observation and interview, the facility failed to ensure 1 of 2 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 4 residents. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., one 'E' type oxygen cylinder were standing upright on the floor of resident room 90 and not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged the 'E' type oxygen cylinders not properly chained or supported in a proper cylinder stand or cart. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)	K 0923	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. The facility properly stored “E” type oxygen cylinders either via chained or supported in proper cylinder stands or carts. 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. 1. All Residents have the potential to be affected by this practice. 2. The facility properly stored “E” type oxygen cylinders either via chained or supported in proper cylinder stands or carts. 3. Education was provided to the Maintenance Director of the regulation of having “E” type oxygen cylinders either stored in proper cylinder stands/carts or chained to prevent tipping over. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	08/10/2022

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			1. The Maintenance Director/designee will ensure proper storage of “E” type oxygen cylinders 5 times a week for 3 months. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	
K 0927 SS=E Bldg. 03	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable			

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	containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms was provided with properly working mechanical ventilation. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 21 residents in one smoke compartment. Findings include: Based on observation and interview during a tour of the facility with the Administrator in Training, Executive Director and Maintenance Director on 07/18/22 between 2:15 p.m. and 6:00 p.m., the oxygen storage room contained large liquid oxygen tanks. the vent did not contain a functional mechanically ventilated exhaust fan. Based on interview at the time of observation, the Executive Director stated the oxygen room fan did not appear to be working. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, Administrator in Training and Maintenance Director present. 3.1-19(b)	K 0927	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice. The facility has installed exhaust fans in all areas needing them for oxygen storage. 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. 1. All Residents have the potential to be affected by this practice. 2. The facility has installed exhaust fans in all areas needing them for oxygen storage. 3. Education was provided to the Maintenance Director of the regulation of having exhaust fans in all areas with oxygen storage and transfilling. 3. What measures will be put into place and what systemic changes will be made to ensure	08/10/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 03 B. WING	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(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
			that the deficient practice does not recur. 1. The Maintenance Director/designee will ensure proper exhaust fans are in all areas of oxygen storage and transfilling 5 times a week for 3 months. 4. 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. 1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-10-2022	