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	09/07/2023

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: 09/07/23 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 96. Quality Review completed on 09/11/23	E 0000		
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the			

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

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

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain	E 0025	Administrator/Designee ensured the facility had a signed transfer agreement with heritage house effective no later than 09/26/2023. The facility has a signed transfer agreement with heritage house	09/26/2023

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	the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 p.m., development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Language in the documentation provided addressed the intent of the facility to have such agreements, however current signed specific agreements with other facilities were not available for review. The ED stated that this was something the corporate office was working to provide each facility. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, and Maintenance Director from another facility present.		this was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation of having a signed transfer agreement with another facility in case of emergency. Administrator/ Designee will audit transfer agreement monthly x 3 to ensure a signed and current transfer agreement with another facility in case of emergencies and obtain new transfer agreement upon administrator turnover, then as determined by the QAA Committee.	
E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).			

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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.			

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	(v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and			

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whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting

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equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency

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	preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 p.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and or for existing staff. Based on an interview at the time of records review, the ED searched during the survey and returned stating that the documentation did not exist. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, and Maintenance Director from another facility present.	E 0037	Maintenance Director/ Designee ensured that facility staff were educated on the Emergency Preparedness Program (EPP) no later than 09/26/2023. The facility has educated staff on the Emergency Preparedness Program. This was completed by 09/26/2023. On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation of having staff educated on the emergency preparedness plan. Administrator/ Designee audit education on EPP monthly x 3 to ensure staff are educated on EPP, then as determined by the QAA Committee	09/26/2023

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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: 09/07/23 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 96 at the time of this survey. Resident Rooms 401 - 410 were not surveyed as part of this survey as the facility was experiencing a COVID 19 outbreak and had isolated that hallway. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. Quality Review completed on 09/11/23	K 0000		

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K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7			
	Based on observation and interview, the facility failed to ensure 3 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect all residents and staff in the East building. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m. the (1) 300 Hall exit near RR#301, (2) the Kitchen Exit to the outside and (3) the 100 & 200 Hall dining area exit, all discharged into the courtyard which was also used as a smoking area. The aforementioned courtyard did not have a hard packed all-weather travel surface leading to a parking lot or to the public way. The courtyard was surrounded by grass and a yard. The ED stated that at one point the exits were marked "Not An Exit" but the facility had been informed during a Fire Marshal Visit that the exit signs needed to be present and that the "Exits" needed to be exits. The ED was unsure if the aforementioned exits were required exits.	K 0271	Maintenance Director/ Designee ensured that the 3 exits leading to the courtyard have a all-weather travel surface leading to a parking lot no later than 10/15/2023. Maintenance Director/ Designee has ensured that the 3 exit leading the courtyard have an all weather travel surface leading to a parking lot. This was completed by 10/15/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation stating all discharges from exits must have a all weather travel surface leading to a parking lot or public access. Maintenance Director/ Designee will audit the building discharges from exit for all weather travel surface leading to a parking lot or public access point monthly x 3 to ensure discharges from exit are proper. Then as determined by QAA committee. Requesting construction waiver due to earliest date for concrete is 10/15/23.	09/26/2023

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	The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)			
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 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			

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	(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 room, was provided with a properly working self-closing device. This deficient practice could affect more than 5 residents, as well as staff and visitors in the 300 Hall. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m. the 300 Hall Mechanical Room, greater than 50 square feet, contained a number of combustible items, such as, paper, cardboard boxes along with over 14 paint cans. The corridor door this mechanical room was did not self-close and latch into the door frame. The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)	K 0321	Maintenance Director/ Designee ensured that storage rooms with greater than 50 square feet that contain combustible items have a self closure with a door that latches into its frame no later than 09/26/2023. Maintenance Director/ Designee ensured that storage rooms with greater than 50 square feet that contain combustible items have a self closure with a door that latches into its frame. This was completed by 09/26/2023. On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation stating that all storage rooms with greater than 50 square feet that contain combustible items must have a self closure with a door that latches into its frame. Maintenance Director/ Designee will audit the building for storage rooms that are greater than 50 square feet with combustible items, for doors with self closures that latch into its frame. This audit will be completed weekly x 4, and then as determined by the QAA committee.	09/26/2023
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	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 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	155491	A. BUILDING 01 B. WING	09/07/2023

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	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 2 staff and 2 residents. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., the following corridor doors in the East Building failed to latch positively into their respective door frames: a) Pantry Corridor Door on 300 Hall b) Resident Room #311 The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)	K 0363	Maintenance Director/ Designee will ensure that doors that do not latch into their frame will do so by 09/26/2023. Maintenance Director/ Designee ensured that doors latched positively into their respective frames. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires doors to latch positively into their respective frames. Maintenance Director/ Designee will audit doors weekly x 4 to ensure they latch positively into their respective frames.	09/26/2023
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required			

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	in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure all smoke barriers walls in the 300 hall were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 6 residents on the 300 hallway. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m. the 300 Hall Med Supply Closet wall was not completely sealed and would not resist the passage of smoke. A 15 x 18 inch hole was evident in the closet wall	K 0372	Maintenance Director/ Designee will ensure that walls do not have holes that cause walls to allow the passage of smoke no later than 09/26/2023. Maintenance Director/ Designee ensured that walls do not have holes that cause walls to allow the passage of smoke. This was completed by 09/26/2023. On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires walls to remain free of holes that cause walls to allow the passage of smoke. Maintenance director/ Designee will audit for holes in walls weekly*4 and then as determined by QAA committee.	09/26/2023

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	which was next to a resident room. The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)			
K 0761 SS=E Bldg. 01				
	Based on observation, records review, and interview; the facility failed to ensure annual inspection and testing of the East Wing fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:	K 0761	On behalf of Majestic Care of Connersville ("Facility"), and in accordance with Indiana Administrative Code Rule and 42 C.F.R. §488.331, we respectfully request a face to face Informal Dispute Resolution with regard to tags K 761 Maintenance, Inspection & Testing - Doors deficiency. The K761 Maintenance, Inspection & Testing - Doors, deficiency cited should be deleted. The deficiency stated: Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 p.m., the provided documentation of the facility's annual inspection for the East Building fire door assemblies was available for review, however the reports were not dated, and it was unclear	09/26/2023

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	(1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents in the East Building. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 p.m., the provided documentation of the facility's annual inspection for the East Building fire door assemblies was available for review, however the reports were not dated, and it was unclear when the inspections were performed. The documentation for the West building was		when the inspections were performed. The documentation for the West building was dated 08/11/23. Based on observation during the tour fire door assemblies in the East Building were observed. Based on interview at the time of records review and observation, the ED acknowledged the annual fire door inspections for the East building were not dated and it was unclear when the inspections occurred. Furthermore, documentation for regular monthly general door inspections was provided, however the documentation did not include the required information necessary for an annual fire door assembly inspection. The surveyor erred in citing this deficiency and is being arbitrary and capricious for stating that there is some question of when the fire door inspections for west building was completed. The surveyor confirms all of the inspections were completed and that the east building was done on August 11, 2023. The fire door inspections were completed by the facility's Maintenance director, the regional director of Plant Operations and the corporate LSC consultant on August 11, 2023 (and as indicted on the facility layout drawings which identify all of the fire doors	

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	dated 08/11/23. Based on observation during the tour fire door assemblies in the East Building were observed. Based on interview at the time of records review and observation, the ED acknowledged the annual fire door inspections for the East building were not dated and it was unclear when the inspections occurred. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, and Maintenance Director from another facility present. 3.1-19(b)		that are to be inspected). There was not lack of a date on the entire packet of door inspections which included both the West and East building. May be one of the individual inspections forms was not dated but the entire packet contains the life safety drawings for the two buildings and more than 30 individual fire door inspections. All of the inspections along with notes, scribbles, and comments on the three-dozen individual fire door inspections are dated and all use the same pen and handwriting (facility Maintenance Supervisor). The surveyors acknowledge that there are dates on most of the documents just not one from the West building, but this does not invalidate the inspections and for the above stated reason the deficiency should be deleted. Maintenance Director/ Designee will ensure that annual fire door inspection is done timely. This will be done no later than 09/26/2023 Maintenance Director/ Designee ensured that the annual fire door inspection was completed timely. This was done by 09/26/2023. On 09/11/2023 the facility administrator educated the maintenance director regarding the	

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			regulation that requires annual fire door inspection.	
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: 09/07/23 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 96 at the time of this survey. Resident Rooms 401 - 410 were not surveyed as part of this survey as the facility was experiencing a COVID 19 outbreak and had isolated that hallway. All areas where residents have customary access were sprinkled and all areas providing facility	K 0000		

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	services were sprinklered. Quality Review completed on 09/11/23			
K 0211 SS=E Bldg. 03	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 over 6 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 15 residents in the facility. Findings include: Based on observations and interview during a	K 0211	Maintenance Director/ Designee ensured that carts in the campus had wheels no later than 09/26/2023 The maintenance director/ designee has ensured that carts in the hallways have wheels. This was completed by 09/26/2023. On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation of having wheels on carts in the hallways. Maintenance Director/ Designee will audit carts in the hallway weekly x 4, then as determined by QAA Committee	09/26/2023

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	tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., in the corridor near Resident Room 609 a cart was being stored in the corridor but was not equipped with wheels allowing the cart to be move out of the hall during an emergency. The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)			
K 0222 SS=E Bldg. 03	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			

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

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	system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 3 of over 6 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 23 residents. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., the exit door located near the activity's office was provided with delayed egress locks but lacked signage indicating the doors can be opened in 15 seconds by pushing on the door. Furthermore, other delayed egress doors throughout the facility were equipped with homemade signage and not the required readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS." The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility	K 0222	Maintenance Director/ Designee ensured that delayed egress doors in the facility have proper signage that reads “Push Until Alarm Sounds. Door can be opened in 15 seconds” no later than 09/26/2023. Maintenance Director/ Designee also ensured that all exit doors with a code posted could be opened using that code no later than 09/26/2023. The maintenance director/ designee have ensured that all delayed egress doors have proper signage that reads “Push until alarms sounds Door can be opened in 15 seconds” This was completed by 09/26/2023. The maintenance director/ designee has also ensured that all exit doors with a code posted open using that code. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation of having the proper signage on delayed egress doors and the same regulation requiring exit doors to have a posted code that can open the doors. Maintenance Director/ Designee will audit the signage on delayed egress doors and the ability to open the doors using the posted code. Weekly x 4, and then as determined by QAA Committee.	09/26/2023

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present.

3.1-19(b)

2. Based on observation and interview, the facility failed to ensure the means of egress through 2 of over 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15, staff and visitors if needing to exit the facility.

Findings include:

Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., the (1) exit door near the activities office and (2) the Therapy Exit door, each marked as facility exits, were magnetically locked and could be opened by entering a four digit code but the code posted was incorrect and did not release and open the doors.

The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present.

3.1-19(b)

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K 0325 SS=E Bldg. 03	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
	Based on observation and interview, the facility failed to ensure 2 of over 20 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a	K 0325	Maintenance Director/ Designee ensured that hand sanitizers were not directly above electrical outlets no later than 09/26/2023. Maintenance Director/ Designee ensured that hand sanitizers were not above electrical outlets. This was completed by 09/26/2023. On 09/11/2023 the facility administrator educated the	09/26/2023

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	1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above an electrical outlet in (1) the dining room rear the bulletin board and (2) in the corridor between Resident Rooms 912 & 913. The Executive Director confirmed the alcohol-based hand sanitizer dispensers were installed on the wall directly above electrical outlets. The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)		maintenance director regarding the regulation stating that hand sanitizers cant be directly above electrical outlets. Maintenance Director/ Designee will audit the building for hand sanitizers directly above electrical outlets weekly x 4. Then as determined by QAA Committee.	
K 0346 SS=C Bldg. 03	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.			

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	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 Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 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 Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. The ED stated that this was an issue last year however during the survey no additional fire watch documentation was provided. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, and Maintenance Director from another facility present. 3.1-19(b)	K 0346	On behalf of Majestic Care of Connersville ("Facility"), and in accordance with Indiana Administrative Code Rule and 42 C.F.R. §488.331, we respectfully request a face to face Informal Dispute Resolution with regard to tags K 346 deficiency. The K 346 Fire Alarm System - Out of Service, deficiency cited should be deleted. The deficiency stated: 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 Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail listed above. The surveyor erred in citating the facility at K 346 Fire Alarm System - Out of Service because the there is no CMS, NFPA or Indiana state mandate which	09/26/2023

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			requires skilled nursing providers to specifically use a specific ‘portal’ or email address to notify the Indiana Department of Health. This ‘portal’ or email would the Indiana Department of Health’s preferred method but is not the law. NFPA 72, National Fire Alarm Signaling Code clearly states that the service provider is responsible for notifying the AHJ when any system is out of service for more than four hours and offers a list of considerations that should be weighed if the building fire alarm system is not functional. Furthermore, the NFPA 101, Life Safety Code state that one of the expected notifications may be to a licensing authority having jurisdiction but it does not require a specific mode of the notification. The facility as confirmed by the surveyor does include in the notification section of the Fire Alarm Outage – Fire Watch policy and procedure the phone number to the Indiana Department of Health which would be reasonable to notify of an engaged fire watch. For the above stated reason, the deficiency K 346 should be deleted as the facility is clearly in compliance having met the degree of burden by including the contact	

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			information of the Indiana Department of Health in its Fire Watch Policy. Administrator/ Designee ensured that a fire watch plan was implemented that included the ISDH Gateway Link no late than 09/26/2023 Administrator/ Designee ensured that the fire watch plan with ISDH Gateway link is implemented. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires the ISDH Gateway Link to be listed as a primary or secondary method of communication. Maintenance Director/ Designee will audit the fire watch plan monthly x3 to ensure that the fire watch plan includes the gateway link as a primary and secondary method of communication and then as determined by the QAA Committee.	
K 0353 SS=E Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____________________ b) Who provided system test ______________________________ c) Water system supply source ____________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler systems was provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the West Building. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., there was one spare sprinkler cabinet in the riser room that included 5 spare sprinklers and the provided spare sprinkler heads did not include 2 of every	K 0353	Maintenance Director/ Designee ensured that there are two spare sprinkler heads of every type of sprinkler head represented in the facility no later than 09/26/2023 Maintenance Director/ Designee ensured that there are two spares of every sprinkler head represented in the facility. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires there to be 2 spares of every type of sprinkler head in the facility. Maintenance Director/ Designee will audit the spare sprinkler heads monthly x 3 and then as determined by the QAA committee.	09/26/2023

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	type and kind of sprinkler head represented in the facility. The Maintenance Director from another facility agreed that the number provided did not meet the requirement and that the type and kind provided did not correspond with each type and kind represented in the facility. The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)			
K 0354 SS=C Bldg. 03	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			
	Based on record review and interview, the facility failed to provide 1 of 1 correct written 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	K 0354	On behalf of Majestic Care of Connersville ("Facility"), and in accordance with Indiana Administrative Code Rule and 42 C.F.R. §488.331, we respectfully request a face to face Informal	09/26/2023

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	procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 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 Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. The ED stated that this was an issue last year however during the survey no additional fire watch documentation was provided.		Dispute Resolution with regard to tags K 354 deficiency. The K 354 Sprinkler System - Out of Service, deficiency cited should be deleted. The deficiency stated: 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 Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail listed above. The surveyor erred in citating the facility at K 354 Sprinkler System - Out of Service because the there is no CMS, NFPA or Indiana state mandate which requires skilled nursing providers to specifically use a specific 'portal' or email address to notify the Indiana Department of Health. This 'portal' or email would the Indiana Department of Health's preferred method but is not the law.	

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	The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, and Maintenance Director from another facility present. 3.1-19(b)		NFPA 25 Inspection, Testing and Maintenance of Water-Based Fire Protection Systems manages the ITM provisions for water-based fire protection systems with the ultimate goal of maintaining system readiness at a high level of reliability. Providing a fire watch is often a preferred method versus evacuation and when there is an outage requires the service provider to make notification to an acceptable authority having jurisdiction (AHJ). Furthermore, the NFPA 101, Life Safety Code state that one of the expected notifications may be to a licensing authority having jurisdiction but it does not require a specific mode of the notification. The facility as confirmed by the surveyor does include in the notification section of the Fire Alarm Outage – Fire Watch policy and procedure the phone number to the Indiana Department of Health which would be reasonable to notify of an engaged fire watch. For the above stated reason, the deficiency K 346 should be deleted as the facility is clearly in compliance having met the degree of burden by including the contact information of the Indiana Department of Health in its Fire Watch Policy. Administrator/ Designee ensured that a fire watch plan was	

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			implemented that included the ISDH Gateway Link no late than 09/26/2023 Administrator/ Designee ensured that the fire watch plan with ISDH Gateway link is implemented. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires the ISDH Gateway Link to be listed as a primary or secondary method of communication. Maintenance Director/ Designee will audit the fire watch plan monthly x3 to ensure that the fire watch plan includes the gateway link as a primary and secondary method of communication and then as determined by the QAA Committee.	
K 0355 SS=E Bldg. 03	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 maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal	K 0355	Maintenance Director/ Designee will ensure that K class fire extinguishers have the proper signage per code. This was done no later than 09/26/2023. Maintenance Director/ Designee ensured that K class fire extinguishers have the proper	09/26/2023

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	oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff in the kitchen. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., a portable K Class fire extinguisher was located in the West Building kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. The proper signage was present in the East Building kitchen (which was not in use) but was missing in the West Building Kitchen (which is in use). The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)		signage. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation the requires K class fire extinguishers to have a sign that indicates the extinguisher is only to be used after the Ansel system is activated. Maintenance Director/ Designee will audit K class fire extinguishers for proper Weekly x 4, and then as determined by the QAA Committee.	
K 0363 SS=E Bldg. 03	NFPA 101 Corridor - Doors Corridor - Doors			

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	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 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			

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

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	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 6 staff and 20 residents. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., the following corridor doors in the West Building failed to latch positively into their respective door frames: a) The Mop Storage Room - equipped with a self-closing device. b) The Kitchen Door near the soda machine - equipped with a self-closing device. c) The Dietary Directors Office d) Resident Room #807 e) Resident Room #810 f) The Storage FOLD room on the 900 hall - equipped with a self-closing device. g) Storage Room in nurses station on 600 Hall - equipped with a self-closing device. The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)	K 0363	Maintenance Director/ Designee will ensure that doors that do not latch into their frame will do so by 09/26/2023. Maintenance Director/ Designee ensured that doors latched positively into their respective frames. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires doors to latch positively into their respective frames. Maintenance Director/ Designee will audit doors weekly x 4 to ensure they latch positively into their respective frames.	09/26/2023
K 0511 SS=E Bldg. 03	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	155491	A. BUILDING 03 B. WING	09/07/2023

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	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. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			
	Based on observation and interview, the facility failed to ensure electrical outlets were protected in the dining area according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 15 residents, staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., in the dining hall near the kitchen door an outlet cover protecting the electrical outlet was not completely covering the receptacle and appeared to be broken with pieces missing. The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)	K 0511	On behalf of Majestic Care of Connersville ("Facility"), and in accordance with Indiana Administrative Code Rule and 42 C.F.R. §488.331, we respectfully request a face to face Informal Dispute Resolution with regard to tags K 511 Utilities - Gas and Electric The K 511 Utilities - Gas and Electric, deficiency cited should be deleted. The deficiency stated: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m., in the dining hall near the kitchen door an outlet cover protecting the electrical outlet was not completely covering the receptacle and appeared to be broken with pieces missing. The surveyor erred in citating the facility at because the receptable plate had just been broken and there was a workorder to maintenance department to replace had already been	09/26/2023

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			submitted. This is a single instance and for the above stated reason above the deficiency K 511 should be deleted as the facility was clearly concerned and recognized the need to replace the receptable plate. Maintenance Director/ Designee ensured that outlet covers completely covered receptacles. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires walls to remain free of holes that could allow the passage of smoke through the smoke barrier. Maintenance Director/ Designee will audit outlet covers to ensure that they completely cover receptacles weekly x 4 and then as determined by QAA committee.	
K 0712 SS=F Bldg. 03	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			

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	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 on each shift for 1 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. This deficient practice affects all staff and residents. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from another facility on 09/07/23 between 10:10 a.m. and 1:20 p.m., the Third Shift First Quarter 2023 fire drill documentation was missing. The Executive Director searched extensively and stated that it appeared the aforementioned drill was not completed during the appropriate shift time. The finding was reviewed with the Executive Director at the time of discovery and again at the exit conference with the Executive Director, and Maintenance Director from another facility present. 3.1-19(b) 3.1-51(c)	K 0712	Maintenance Director/ Designee will ensure that fire drills are completed per regulation requirements no later than 09/26/2023 Maintenance director/ Designee ensured that fire drills are completed per regulation. This was completed by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires one fire drill per shift per quarter. Maintenance Director/ Designee will audit weekly x 4 and then as determined by the QAA Committee to ensure that fire drills are done as the regulation requires.	09/26/2023
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and			

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	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			
	Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 staff in the ISPD office. Findings include: Based on observations and interviews during a tour of the facility with the Executive Director and Maintenance Director from another facility on 09/07/23 between 1:20 p.m. and 4:50 p.m. in room	K 0920	Maintenance Director/ Designee will ensure that high draw equipment is plugged into electrical receptacles not power strips. This will be done no later than 09/26/2023 Maintenance Director/ Designee ensured that high draw equipment is plugged into electrical receptacles instead of power strips. This was done by 09/26/2023 On 09/11/2023 the facility administrator educated the maintenance director regarding the regulation that requires high draw	09/26/2023

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	described by the ED as the "ISPD Office" a power strip was being used to power a dorm style refrigerator (high power draw equipment). The finding was acknowledged by the Executive Director and Maintenance Director from another facility at the time of discovery and again at the exit conference with the Executive Director and Maintenance Director from another facility present. 3.1-19(b)		equipment to be plugged into electrical receptacles instead of power strips. Maintenance Director/ Designee will audit weekly x 4 to ensure high draw equipment is plugged directly into electrical receptacles.	