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	03/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 03/16/21 Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Emergency Preparedness survey, Majestic Care of Connersville was found not in 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 70. Quality Review completed on 03/23/21	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.			

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

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	The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include:	E 0004	1. the allegation is that the facility failed to develop and maintain an emergency preparedness plan. It was not reviewed and updated annually. 2. No residents were affected but all residents had potential to be at risk by the deficient practice. 3. The Administrator immediately	04/19/2021

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	Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plans were not dated as reviewed within the most recent twelve month period. Based on interview at the time of record review, the Executive Director agreed the emergency program documentation was not dated as reviewed within the most recent twelve month period. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		updated and reviewed to EP binder. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks and then monthly for 6 months. Results of the audit will be presented to the QA committee.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*			

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	(2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk			

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	assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, was not available for review. Based on	E 0006	1.The allegation is that the facility failed to maintain a risk assessment and was not available for review. 2. No residents were effected, but all residents had the potential to be at risk by this deficient practice. 3. The Administrator has updated an updated Risk Assessment utilizing an all hazards approach. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly x 6 months. Results of audit findings will be presented to QA committee.	04/19/2021

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	interview at the time of record review, the Executive Director agreed a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, specific to Majestic Care of Connersville was not available for review at the time of the survey. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.			
E 0007 SS=C Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a)(3):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of			

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	operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, no documentation could be found ensuring the emergency preparedness plan addressed the resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. Based on interview at the time of record review, the Executive Director agreed she was unable to provide policies regarding the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. This finding was reviewed with the Executive	E 0007	1. The allegations is that the facility did not maintain a facility based and community based risk assessment, utilizing an all hazards approach, specific to Majestic Care of Connersville. 2. No residents were affected, but all residents had potential to be at risk by this deficient practice. 3. The Administrator immediately placed an updated community based risk assessment and utilizing an all hazards approach specific to Majestic Care of Connersville in the EP manual. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA tool Weekly for 4 weeks and then monthly x 6 months. Results of audit findings will be presented to the QA committee.	04/19/2021

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	Director and the Maintenance Director during the exit conference.			
E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities			

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	only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review	E 0015	1. The allegations is that the facility did not have the EP documentation in place to include subsistence needs for food, water or pharmaceutical review. 2. No residents were affected, but all residents in those areas had the potential to be at risk by this deficient practice. 3. The Administrator immediately placed all information needed for subsistence need for food, water and pharmaceutical review in the EP binder. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly x 6 months. Results of audit findings will be presented to the QA committee.	04/19/2021

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	from 2:30 p.m. to 3:45 p.m. on 03/16/21, subsistence needs documentation for the emergency preparedness program was incomplete. The documentation did not include subsistence needs for food, water, pharmaceutical supplies and temperature extremes. Based on interview at the time of record review, the Executive Director agreed emergency preparedness program documentation did not include all subsistence needs. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.			
E 0018 SS=C Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and			

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	location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and			

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	alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b)(2). This deficient practice could affect all occupants, Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review,	E 0018	1. The allegation is that the facility had no policy or procedure to track staff and resident during an emergency. 2. No residents were affected, but all residents had the potential to be at risk by this deficient practice. 3. The Administrator immediately placed the policy and procedure to track staff and residents during an emergency into the EP binder. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks and monthly x 6 months.	04/19/2021

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	the Executive Director confirmed no policies and procedure for tracking staff and residents was available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.			
E 0020 SS=C Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities.			

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	(iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the LTC facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.73(b)(3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan)	E 0020	1. The allegation is that the facility had no documentation that showed alternate means of communication. 2. No residents were affected, but all residents had the potential to be at risk by this deficient practice. 3. The Administrator added alternate means of communication the ED manual. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly x 6 months. Results of audit finding will be	04/19/2021

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

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	documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, the facility's Emergency Preparedness Program documentation did not include primary and alternate means of communication with external sources of assistance during an emergency. Based on interview at the time of record review, the Executive Director agreed primary and alternate means of communication was not documented. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		presented to the QA committee.	
E 0022 SS=C Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):]			

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

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	Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, documentation of emergency preparedness policies and procedures for sheltering in place during an emergency was not available for review. Based on interview at the time of record review, the Executive Director agreed the emergency preparedness plan for the facility did not include documentation of emergency preparedness policies and procedures for sheltering in place. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.	E 0022	1. The allegation is that the facility did not include documentation of emergency preparedness policies and procedures for sheltering in place in the EP binder. 2. No resident was affected but all residents had the potential to be at risk by this deficient practice. 3. The Administrator immediately added the policy and procedure for sheltering in place in the EP binder. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, the monthly x 6 months. Results of audit findings will be presented to the QA committee.	04/19/2021
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8),			

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

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	485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants.	E 0026	1. The allegation is that the facility did not expressly state the role of the facility under a waiver declared by the Secretary. 2. No other residents were affected, but all residents had the potential to be at risk by the deficient practice. 3. The Administrator immediately added the role of the facility under	04/19/2021

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	Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, the emergency preparedness plan for the facility did not expressly state the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Executive Director agreed the emergency preparedness plan for the facility did not expressly state the role of the facility under a waiver declared by the Secretary. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		a waiver declared by the Secretary to the EP binder. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly x 6 months. Results of audit findings will be presented to the QA committee.	
E 0032 SS=C Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and			

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	local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c)(3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, the Emergency Preparedness Program documentation did not include primary and alternate means for communicating with staff, Federal, State, tribal, regional, or local emergency management agencies. Based on interview at the time of record review, the Executive Director agreed all policies and procedures including the primary and alternate means for communicating with staff, Federal, State, tribal, regional, or local emergency management agencies was not available for review. This finding was reviewed with the Executive	E 0032	1. The allegation is that the facility did not have available the policies and procedures including the primary and alternate means for communication with staff, federal, state, tribal regional or local emergency management agencies in the EP manual. 2. No residents were affected but residents had the potential to be at risk by this deficient practice. 3. The Administrator immediately added the alternate means of communication with staff, federal, state, tribal, regional or local emergency management agencies into the WP manual. 4. To ensure compliance the Administrator or Designe will be responsible to complete the QA monitoring tool weekly for 4 weeks, then Monthly x6. Results of audit findings will be presented to the QA committee.	04/19/2021

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	Director and the Maintenance Director during the exit conference.			
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at			

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	least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include:	E 0036	1. The allegation is that the facility documentation did not include a statement that staff training on emergency preparedness policies and procedures would be conducted and documented, on an annual bases. 2. No residents were affected, but residents had the potential to	04/19/2021

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	Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, the facility's emergency preparedness training and testing program documentation was incomplete. The documentation failed to include a statement that staff training on emergency preparedness policies and procedures would be conducted and documented, at a minimum, on an annual basis. Based on interview at the time of record review and at the exit interview at 3:00 p.m., the Executive Director agreed the documentation did not include a statement that staff training on emergency preparedness policies and procedures would be conducted and documented, at a minimum, on an annual basis. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		be at risk by this deficient practice. 3. The Administrator immediately placed statement that staff training on emergency preparedness policies and procedures would by conducted and documented on an annual basis in the ED binder. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly x 6 months. Results will be presented to the QA committee.	
E 0037 SS=F 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 *[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			

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	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. (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			

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	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 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			

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

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	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 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			

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	155491	A. BUILDING -- B. WING	03/16/2021

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

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	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 preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a 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 roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review	E 0037	1. The allegation is that the facility failed to show staff training on the emergency preparedness program documentation for most recent twelve month period was not available. 2. No residents were affected but other residents had the potential to be at risk by this deficient practice. 3. The Administrator immediately started and finished staff training on the emergency preparedness documentation. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly x 6 months. Results of audit findings will be presented to the QA committee.	04/19/2021

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	155491	A. BUILDING -- B. WING	03/16/2021

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	from 2:30 p.m. to 3:45 p.m. on 03/16/21, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Executive Director stated staff training on the emergency preparedness program documentation within the most recent twelve month period was not available for review at the time of the survey. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.			
E 0039 SS=F 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 *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, 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			

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	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. *[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			

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	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 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,			

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	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 accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made			

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	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 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.			

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	(B) If the [LTC facility] 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 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			

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	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, 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 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,			

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	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 the [RNHCI's and OPO's] emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. 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 in a community-based or individual, facility-based full-scale 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 individual, facility-based. (B) a tabletop exercise that includes 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; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 0039	1. The allegation is that the facility did not have any documentation for community based disaster drill or table top exercise conducted within the most recent twelve month period. 2. No resident was affected but residents had the potential to be at risk by this deficient practice. 3. The Administrator immediately started table top exercises with staff. 4. To ensure compliance the Administrator or Designee will be responsible to complete the QA monitoring tool weekly for 4 weeks, then monthly x 6 months. Results of audit will be presented to the QA committee.	04/19/2021

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	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 review of the facility's "Emergency Preparedness Plan (Disaster Plan) documentation with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, documentation of community based disaster drills or table top exercise conducted within the most recent twelve month period was not available for review. Based on interview at the time of record review, the facility is currently experiencing the Covid-19 pandemic disaster but agreed documentation for an additional community based disaster drill or a table top exercise conducted within the most recent twelve month period was not available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.			
K 0000 Bldg. 05	A Life Safety Code Preoccupancy survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). The renovation in Building 05 is for the remodeling resident rooms in the 400 and (formerly unlicensed) 500 wing of the east building into a dedicated ventilator unit (four semi-private and six private resident rooms), to include the remodeling a former medication room into an oxygen storage room, a soiled holding room into a bathing room, an office into a dining and	K 0000		

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	155491	A. BUILDING 05 B. WING	03/16/2021

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	activity room, a reception area and storage rooms into a nurse station and medication room, and three other rooms into a corridor, two laundry rooms (soiled and clean), and a mechanical room. Vent unit will be Rooms 401, 402, 409, and 410 each with two (2) licensed beds and rooms 403, 404, 405, 406, 407, and 408 each with one (1) licensed bed, for a total of fourteen (14) Vent beds. Remodeling in the 200 Wing of a medication room, a nurse station, and a closet into a resident lounge and a mechanical closet; a storage room and a linen closet into two mechanical rooms. Conversion of the 100 unit and portions of the 200 unit into a single locked unit; to include reconfiguring a common space for the south wing and a public lobby outside the units to connect the two corridors; converting a medications room, a soiled utility room, and a clean utility room into a reception desk; a clean utility room, a soiled utility room, and a mechanical closet. Also included is remodeling of a closet to enlarge a nurse station; a nurse station and an office into a staff breakroom; an entrance alcove into a receiving room and storage area; and adding a service counter to an existing dining room. There was also a reconfiguring of two bathing rooms and adjacent closet into mechanical rooms. Locked unit will be rooms 101-115, 201-213, 301-317. Renumbering of rooms in this building to accommodate construction changes. General remodeling of office and support areas, replacement of HVAC systems throughout, and replacement of the generator and automatic transfer switches to provide a Type-1 essential electrical system (EES) for the ventilator wing. Survey Date: 03/16/21			

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	Facility Number: 000316 Provider Number: 155491 AIM Number: 100286370 At this Preoccupancy 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 renovated portions of Building 05 were surveyed under Chapter 18 and 410 IAC 16.2. The facility consisted of two, one story buildings, the East Building and the West Building, which were determined to be of Type V (111) construction and the West Building is fully sprinkled. The East Building is fully sprinklered except for the newly constructed automatic transfer switch room which is attached to the building. 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 70 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered except for the newly constructed automatic transfer switch room which is attached to the East Building. Quality Review completed on 03/23/21			
K 0100 SS=E	NFPA 101 General Requirements - Other			

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

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Bldg. 05	General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 6 sets of smoke barrier doors in accordance with 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the 200 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the following was noted: a. the latching hardware at the top and the bottom of the south door in the corridor door set in the 200 Hall failed to latch into the door frame when tested to close multiple times. The latching hardware on the door failed to protrude into the latching plate on the door frame and on the floor. b. the corridor door to the 400 Hall electrical room was equipped with a self closing device but the device was partially disconnected which prevented the door from self closing and latching into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors would not latch into the door frame when tested to close multiple times.	K 0100	1. The allegation is the the latching hardware at the top and the bottom of the south door in the 200 hall failed to latch into the door frame. The latching hardware on the door failed to protrude into the latching plate on the door frame and on the floor. Plus the corridor door to the 400 hall electrical room was equipped with a self closing device but the device was partially disconnected and it prevented the self closing and latching door to not latch. 2. No residents were affected. No residents live in this area of the LTC. 3. The Maintenance Director immediately fixed these problems by readjusting the door latches. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool daily Monday-Friday for 2 weeks, then weekly for 4 weeks, then monthly for 3 months. Results of audit findings will be presented to the QA committee.	04/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 05 B. WING	03/16/2021

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	This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0161 SS=F Bldg. 05	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised			

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	automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the required building construction type of Type V(111) construction in 1 of 1 automatic transfer switch rooms in the East Building. This deficient practice could affect all residents, staff and visitors in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, all interior walls and the underside of the roof of the newly constructed automatic transfer switch room attached to the building outside the 400 Hall dining room consisted of particle board and wood studs. The fire resistance rating of the wood was not printed on the wood and was not available for review. Based on interview at the time of the observations, the Maintenance Director stated the room was newly constructed to house the new automatic transfer switches and the fire resistance rating for the wood was not available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0161	1. The allegation is that the facility did not make available the review for the fire resistance rating for the wood in the automatic transfer switch room attached to building outside the 400 hall dining room. Arch/Engineer interpretation of code requirements for exterior attached ATS room to existing structure with existing min (1) hr fire rating on interior walls (dining/mech/clean linen). 2. No residents were affected, other residents in those areas had the potential to be at risk by this deficient practice. 3. Installed type X fire rated (4hr) drywall to ATS room wall studs and roof rafters with (2) mud coats over screws and taped joints. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool daily for 2 weeks, weekly 4 weeks, and monthly for 3 months. Facility Maintenance to conduct structural integrity inspection of ATS room during	04/19/2021

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			routine/scheduled maintenance procedures/inspections. Results of audit findings will be presented to the QA committee. Title of person responsible for implementing acceptable POC: Project Manager/Facility Maintenance Dept.	
K 0222 SS=E Bldg. 05	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			

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	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 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 2 of 3 exits in the 400 Hall were readily accessible for residents without a clinical diagnosis requiring specialized security	K 0222	1. The allegation is that the exit door by the Nurses Station on the 400 hall was not equipped with signage indicating the door could be opened after pushing for 15	04/19/2021

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	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 14 residents, staff and visitors if needing to exit the 400 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the west exit in the 400 Hall by the dining room and the exit door set in the corridor by the 400 Hall oxygen storage room were both marked as a facility exit, were magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned doors were marked as a facility exit and could be opened by entering a four digit code but the code was not posted. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised		seconds. 2. No residents, staff or visitors were affected, but residents had the potential to be at risk by this deficient practice. 3. The Maintenance Director immediately had signage ordered and placed at 400 hall exit door. Signage has been placed. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool daily Monday- Friday for 4 weeks, then weekly for 4 weeks, the monthly for 3 months. Passive inspection by Maint./staff to ensure signage remains posted. Scheduled regulatory inspections.	

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	automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 14 residents, staff and visitors if needing to exit the 400 Hall. Findings include:			

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	Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the exit door set to the outside of the facility in the 400 Hall by the nurse's station was marked as a facility exit with an exit sign and was locked and was not equipped with signage indicating the door could be opened after pushing for 15 seconds. The exit door set released to open after pushing for 15 seconds when tested multiple times. In addition, the doors could also be opened by entering a four digit code but the code was not posted. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned exit door set at the 400 Hall nurse's station was not equipped with the necessary signage indicating the door set could be opened after pushing for 15 seconds. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 05	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			

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	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)			
	1. Based on observation and interview, the facility failed to ensure 3 of over 10 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the entry door to the 200 Hall natural gas fired furnace room and the entry door to the room identified as Room 223, which is inside the employee Breaker, each were not equipped with a self closing device. Room 223 also contained a natural gas fired furnace. Room 223 also had the following	K 0321	1. The allegation is that the entry door to the 200 hall furnace room and the entry door to room 223 were not equipped with a self closing device. Room 223 had openings in the wall and ceiling which did not separate the room from other spaces with smoke resistant partitions. Self closing device in the 400 hall self closing device failed to latch. Scott door was notified that a new custom fit door would be needed as soon as possible. 2. No residents were affected but had the potential to be at risk by this deficient practice. 3. The Maintenance Director immediately patched and fire	04/09/2021

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	openings in the wall and ceiling of the room which did not separate the room from other spaces with smoke resistant partitions: a. a twelve inch by two inch hole in the east wall of the room. b. a three inch by one inch rectangular shaped hole in the west wall of the room near the floor. ac. the annular space surrounding a two inch in diameter PVC pipe which penetrated the west wall of the room. d. the annular space surrounding a three inch in diameter PVC pipe for the furnace exhaust or fresh air intake which penetrated the ceiling of the room. e. the hole next to the ceiling mounted sprinkler in the room. In addition, the entry door to the natural gas fired furnace room inside the 100 Hall Bathing room had a one and three quarters inch gap between the bottom of the door and floor. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous areas such as laundries (greater than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the		caulked the openings. all self closing devices were fixed. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks, and every month for 3 months.	

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	vicinity of the new laundry and clean utility rooms. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the corridor door to the soiled Laundry room in the 400 Hall and the corridor door to the Clean Utility room in the 400 Hall were each equipped with a self closing device but each door failed to latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous area's corridor door would not resist the passage of smoke and did not self close and latch into the door frame when tested to close multiple times. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0331 SS=F Bldg. 05	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____			

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	Based on observation and interview, the facility failed to ensure one of one automatic transfer switch rooms in the East Building was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all residents, staff and visitors in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, all interior walls and the underside of the roof of the newly	K 0331	1. The allegation is that the building outside the 400 hall dining room consisted of particle board and wood studs. no flame spread rating was printed on the wood. 2. No residents wee affected but had the potential to be at risk by this deficient practice. 3. Type X fire rated drywall over ATS room walls and ceiling. Applied intumescet (fire retardant) paint over north wall of ATS room. Drywall & intumescent paint have Class A rating. 4. To ensure compliance the Maintenance Director or "Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks, every month for 3 months. All findings will be presented to QA committee. Facility Maintenance to conduct structural integrity inspection of ATS room during routine/scheduled maintenance procedures/inspections. Title of person responsible for implementing acceptable PoC: Project Manager/Facility Maintenance Dept.	04/19/2021

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	constructed automatic transfer switch room attached to the building outside the 400 Hall dining room consisted of particle board and wood studs. The flame spread rating of the wood was not printed on the wood and was not available for review. In addition, the south wall of the 400 Hall mechanical room had wood paneling affixed to the wall from the floor to the ceiling with no affixed flame spread rating documentation. Based on interview at the time of the observations, the Maintenance Director stated the room was newly constructed to house the new transfer switches, the flame spread rating documentation for the wood was not available for review and he was not aware if the wood had been treated with a flame retardant material. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0351 SS=F Bldg. 05	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms			

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	where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. The facility failed to ensure 1 of 1 automatic transfer switch rooms were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. This deficient practice could affect all residents, staff and visitors in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the newly constructed automatic transfer switch room, which is attached to the outside of the building near the 400 Hall Dining Room, was not provided with automatic sprinklers. Based on interview at the time of the observations, the Maintenance Director stated the room was newly constructed as part of the renovation to accommodate the vent unit beds and agreed the newly constructed automatic transfer switch room does not have sprinkler coverage. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-19(ff) 2. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were installed in accordance	K 0351	1. The allegation is that the facility did not place a automatic sprinkler to the outside building near the 400 hall dining room. The escutcheon for the ceiling mounted sprinkler in the 100 hall closet in bathing room was missing its escutcheon. A deflector for the upright sprinkler in 400 hall attic was embedded in the layer of drywall. A hole was noted outside the exit door set from the 400 hall by nurse's station. Arch/Engineer interpretation of code requirements for exterior attached ATS room to existing structure with existing min. (1) hr fire rating on interior walls (dining/mech/clean linen). 2. No residents were affected but had the potential to be at risk by this deficient practice. 3. The Maintenance Director had Safecare correct the findings. Safecare installed sprinkler head in ATS room.Cover plate was installed over 2" hole at underside of 400 east canopy. Safecare lowered the sprinkler head that was embedded in (1) layer of drywall in the 400 attic near south wall at (2) hr	04/19/2021

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	with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 6.2.7.2 states escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. Section 6.2.7.3 states cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect over 15 residents, staff and visitors in the vicinity of the 100 Hall Bathing Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the escutcheon for the ceiling mounted sprinkler in the closet in the 100 Hall Bathing Room was missing its escutcheon. Based on interview at the time of the observations, the Maintenance Director agreed the escutcheon for the aforementioned sprinkler location was missing. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of over 50 attic mounted sprinkler heads in the facility were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.6.4.1.2 states under obstructed construction, the sprinkler deflector shall be located in accordance with one of the following arrangements: (1) Installed with the deflectors within the horizontal planes of 1 in. to 6 in. (25.4 mm to		firewall accessed from clean laundry room. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks, and every month for 3 months. Results of findings will be presented to the QA committee.	

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	152 mm) below the structural members and a maximum distance of 22 in. (559 mm) below the ceiling/roof deck (2) Installed with the deflectors at or above the bottom of the structural member to a maximum of 22 in. (559 mm) below the ceiling/roof deck where the sprinkler is installed in conformance with 8.6.5.1.2 escutcheons used with recessed, flush-type or concealed sprinklers shall be part of a listed sprinkler assembly. (3) Installed in each bay of obstructed construction, with the deflectors located a minimum of 1 in. (25.4 mm) and a maximum of 12 in. (305 mm) below the ceiling (4) Installed with the deflectors within the horizontal planes 1 in. to 6 in. (25.4 mm to 152 mm) below composite wood joists to a maximum distance of 22 in. (559 mm) below the ceiling/roof deck only where joist channels are firestopped to the full depth of the joists with material equivalent to the web construction so that individual channel areas do not exceed 300 ft 2 (27.9 m 2) (5)*Installed with deflectors of sprinklers under concrete tee construction with stems spaced less than 71.2 ft (2.3 m) but more than 3 ft (0.91 m) on centers, regardless of the depth of the tee, located at or above a horizontal plane 1 in. (25.4 mm) below the bottom of the stems of the tees and shall comply with Table 8.6.5.1.2. Section 8.6.4.2.1 states unless the requirements of 8.6.4.2.2 or 8.6.4.2.3 are met, deflectors of sprinklers shall be aligned parallel to ceilings, roofs, or the incline of stairs. This deficient practice could affect over 14 residents, staff and visitors in the 400 Hall. Findings include: Based on observations with the Maintenance			

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	Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the deflector for the upright sprinkler mounted in the 400 Hall attic near the south wall of the two hour fire wall accessed from the Clean Laundry Room attic access door was embedded in the one layer of drywall affixed to the underside of the roof above. A picture was taken and shown to the Maintenance Director who agreed the upright sprinkler in the 400 Hall attic was not correctly installed. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to maintain the canopy construction in 1 of 3 exterior canopies in the East Building. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 14 residents, staff, and visitors in the 400 Hall in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, a two inch in diameter hole was noted in the exterior canopy			

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	outside the exit door set from the 400 Hall by the nurse's station. The hole was within six inches of one sprinkler installed on the underside of the canopy. Based on interview at the time of the observations, the Maintenance Director agreed there was a hole on the underside of the canopy outside the exit door set from the 400 Hall by the nurse's station. 3.1-19(b)			
K 0353 SS=F Bldg. 05	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. 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 1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2	K 0353	1. The allegation is that the dry pipe sprinkler system for the East building needs to be flushed. Weekly inspections on dry sprinkler system has not been done. Not all spare sprinklers on the premises were stored in the spare sprinkler cabinet in the 100	04/19/2021

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	requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the East Building. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler: Five Year Internal Pipe Inspection" documentation dated 01/12/21 with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, the dry pipe sprinkler system for the East Building needs to be flushed. The "Inspection Results" section of the 01/12/21 report stated "Found rust and sediment buildup in the crossmain" but it did not state the system was impaired. Review of sprinkler flush proposals from two different contractors dated 01/21/21, 01/28/21 and 02/12/21 indicated none of the proposals have been signed by the facility. Based on interview at the time of record review, the Executive Director and the Maintenance Director stated the dry sprinkler system needs to be flushed, the facility has not closed on any bid for the dry sprinkler system flush and agreed a dry sprinkler system flush has not yet been performed.		hall sprinkler riser room. The deflector for the ceiling mounted sprinkler near entrance to the bathroom in room 405 were painted Sprinkler heads in the attic 400 hall soiled linen room and above the 400 hall clean laundry room were covered with sprayed attic insulation. 2. No residents were affected but had the potential to be at risk by this deficient practice. 3. qualified contractors have submitted proposals to flush East Bldg. system. It is anticipated the contract will be awarded to the contractor that can schedule the flush no later than week of 4/12. Contract/documentation will be submitted upon award. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, weekly for 4 weeks, monthly for 3 months. Results of audit findings will be presented to the QA committee. Software utilized by facility to schedule routine inspections of sprinkler system gauges/valves has been re-formatted for weekly inspections v twice monthly inspections. Maint. Dept. to document accordingly.	

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	This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3-1.19(b) 2. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the East Building. Findings include: Based on review of the sprinkler system contractor's "Sprinkler: Report of Inspection" documentation dated 04/06/20, 07/16/20, 10/27/20 and 01/12/21, weekly dry sprinkler system gauge and valve inspections were documented for 4 weeks of the most recent 52			

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	week period. Monthly wet sprinkler system gauge and valve inspections were documented by the contractor for 4 months of the most recent 12 month period by the contractor on the aforementioned four inspection reports. Based on interview at the time of record review, the Maintenance Director stated the facility inspects dry and wet sprinkler system gauges and valves monthly as documented in "Fire System Monthly Log" documentation for the most recent twelve month period. Review of "Fire System Monthly Log" documentation indicated the facility performs monthly checks for dry sprinkler system gauges and does not document weekly inspections on dry sprinkler system gauges. Based on interview at the time of record review, the Maintenance Director stated dry sprinkler system gauges are inspected by the facility monthly not weekly. Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the facility has supervised wet and dry sprinkler systems. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler systems' spare sprinklers were kept in a cabinet. 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			

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	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, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, four spare sprinklers were stored on top of the wall mounted spare sprinkler cabinet in the 100 Hall sprinkler riser room. Based on interview at the time of the observations, the Maintenance Director agreed not all spare sprinklers on the premises were stored in the spare sprinkler cabinet in the 100 Hall sprinkler riser room. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure over more than 20 of over 200 sprinkler heads in the facility which had been painted or loaded with foreign materials were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and			

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	physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect all residents, staff and visitors in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, sprinkler heads in the attic above the 400 Hall Soiled Lined Room and above the 400 Hall Clean Laundry Room were covered with sprayed on attic insulation. In addition, the deflector for the ceiling mounted sprinkler near the entrance to the bathroom in Room 405 was painted. Based on interview at the time of the observations, the Maintenance Director the aforementioned sprinkler head locations had foreign materials on them or were painted. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.			

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	3.1-19(b) 5. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect over 14 residents, staff and visitors in the 400 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, a long yellow strand of light bulbs was affixed to horizontal sprinkler pipe in the 400 Hall attic near the north wall of two hour fire wall accessed from the Clean Laundry Room attic access door. Based on interview at the time of the observations, the Maintenance Director agreed sprinkler piping in the attic was used to support nonsystem components. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 05	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected,			

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	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 ensure 1 of over 10 portable fire extinguishers were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could over 10 residents, staff and visitors in the 100 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the ABC portable fire extinguisher located in the 100 Hall electrical room was freestanding on the floor and was not secured or supported. The fire extinguisher contractor had affixed a hanging tag to the extinguisher documenting the most recent annual maintenance was performed in March 2020. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was freestanding on the floor and was not mounted. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0355	1. The allegation is the ABC portable fire extinguisher located in the 100 hall electrical room was standing on the floor and not secured. 2. No residents were affected but had the potential to be at risk by this deficient practice. 3. The Maintenance Director immediately secured fire extinguisher to the wall. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks and every month for 3 months. Results of audit findings will be presented to the QA committee.	04/19/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 05 B. WING	03/16/2021

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K 0362 SS=E Bldg. 05	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to ensure 2 of over 20 corridor walls was constructed to resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, a one inch hole for the passage of cables was noted in the corridor wall behind the wall mounted computer touch screen by Room 104 in the 100 Hall and by Room 210 in the 200 Hall. Based on	K 0362	1. The allegation is that the 100 hall corridor wall had a hole for the passage of cables by room 104 and by room 210 in 200 hall. 2. No resident was affected but had the potential to be at risk by this deficient practice. 3. The Maintenance Director immediately fire caulked all holes. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 week, weekly for 4 weeks, every month for 3	04/19/2021

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	interview at the time of the observations, the Maintenance Director agreed the aforementioned openings in the corridor wall would not resist the passage of smoke. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		months. Results of audit finding will be presented to the QA committee.	
K 0372 SS=F Bldg. 05	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 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. 1. Based on observation and interview, the facility failed to ensure 3 of 5 smoke barrier walls were protected to maintain the fire resistance of the 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. This deficient practice could affect all residents, staff and visitors in the East Building. Findings include:	K 0372	1. The allegation is that the access door in the 100 hall attic was propped open. Each of the three smoke barrier wall attic access doors were affixed. Holes were noted in the ceiling smoke barrier above the electrical panel in the 400 hall electrical room. 2. No residents were affected but had the potential to be at risk by this deficient practice. 3. The Maintenance Director	04/19/2021

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	Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the wall mounted access door in the 100 Hall smoke barrier wall in the attic was propped open. The wall mounted access door in the 400 Hall smoke barrier wall in the attic was also propped open. The wall mounted access door in the 200 Hall smoke barrier wall in the attic was in the fully open position because the spring which served as the self closing device for the door was dangling from the door. Each of the three smoke barrier wall attic access doors was affixed with a 90 minute fire resistance rating label. Each attic smoke barrier wall consisted of two layers of 5/8ths inch thick drywall on each side of the wall studs. In addition, a two inch gap was noted between the edge of the drywall and the frame for the access door in the 400 Hall smoke barrier wall in the attic. Two open ended conduits, which were not firestopped, for the passage of cables was also noted above the wall mounted attic access door. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings in the smoke barrier wall did not maintain the fire resistance rating of the wall. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits,		closed all access doors in the attic. All holes in ceiling smoke barrier above electrical panel in 400 hall electrical room repaired. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks and every month for 3 months. Results of audit findings will be presented to the QA committee.	

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	pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the 400 Hall mechanical room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, holes were noted in the ceiling smoke barrier above the electrical panel identified as "ECR1 Feed" in the 400 Hall electrical room by the nurse's station. Based on interview at the time of the observations, Maintenance Director agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0511 SS=F Bldg. 05	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas			

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	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 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 all residents, staff and visitors in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the wall mounted electrical panel in the corridor by the 200 Hall receiving room identified as "ELS1" and the wall mounted electrical panel in the corridor by Room 101 were each not locked. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned electrical panels in the corridor were not secured from non-authorized personnel.	K 0511	1. The allegation is that the wall mounted electrical panel in the corridor by the 200 hall receiving room wall mounted electrical panel in the corridor by room 101 were each not locked. 2. No resident was affected but had potential to be at risk by this deficient practice. 3. The Maintenance Director immediately locked both panels. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks and every month for 3 months.	04/19/2021

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	This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0911 SS=E Bldg. 05	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) 1. Based on observation and interview, the facility failed to ensure all circuits on the life safety branch supply power to circuits essential for life safety in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.2.2.3.2 states the life safety branch shall supply power for lighting, receptacles, and equipment as follows: (1) Illumination of means of egress in accordance with NFPA 101, Life Safety Code. (2) Exit signs and exit directional signs in accordance with NFPA 101, Life Safety Code. (3) Hospital communication systems, where used for issuing instruction during emergency conditions. (4) Generator set location as follows: (a) Task illumination (b) Battery charger for emergency battery-powered lighting unit(s) (c) Select receptacles at the generator set location and essential electrical system transfer switch locations (5) Elevator cab lighting, control,	K 0911	1. The allegation is that the facility did not have the Nurse's call circuit on the critical branch circuit. Multiple items were stored in front of the electrical panel. 2. No residents were affected but had the potential to be at risk by this deficient practice. 3. The Maintenance Director immediately removed all debris from in front of the electrical panel. Electrical company called in to place the Nurse's call circuit onto the critical branch circuit. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks, and every month for 3 months.	04/19/2021

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	communications, and signaling systems. (6) Electrically powered doors used for building egress. (7) Fire alarms and auxiliary functions of fire alarm combination systems complying with NFPA 72, National Fire Alarm and Signaling Code. Section 6.4.2.2.3 states alarm and alerting systems (other than fire alarm systems) shall be connected to the life safety branch or the critical branch. Section 6.4.2.2.3.4 states loads dedicated to a specific generator, including the fuel transfer pump(s), ventilation fans, electrically operated louvers, controls, cooling systems, and other generator accessories essential for generator operation, shall be connected to the life safety branch or the output terminals of the generator with over-current protective devices. Section 6.4.2.2.3.5 states no functions other than those in 6.4.2.2.3.2, 6.4.2.2.3.3, and 6.4.2.2.3.4 shall be connected to the life safety branch, except as specifically permitted in 6.4.2.2.3. Section 6.4.2.2.6.1 states the life safety branch shall be kept independent of all other wiring and equipment. This deficient practice could affect 14 residents. Findings include: Based on observations with the Maintenance Director and the electrical contractor during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the nurse's call circuit in the wall mounted "ELS1" subpanel in the 100/200 Hall corridor was fed from the circuits in the life safety branch panel identified as "ELS400" in the 400 Hall mechanical room. Based on interview at the time of the observations, the electrical contractor agreed the nurse's call circuit should be on the critical branch circuit and not the life			

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	safety branch. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of over 2 mechanical rooms in the East Building. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect over 10 residents, staff and visitors in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, two 44 gallon trash carts, a folding chair, a portable cart and window blinds in cardboard boxes were all stored within three feet of the three electrical panels identified as Panel A, Panel B and Panel C in the 100 Hall mechanical room. Based on interview			

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	at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of or under the electrical panels at the aforementioned location. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 05	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records			

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	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) 1. Based on record review and interview, the facility failed to exercise the generator for 1 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Power	K 0918	1. The allegation is that on 1-29-21 a monthly load test for the diesel powered generator was not documented. No battery powered emergency lighting was attached to the outside building near the 400 hall dining room. 2. No resident was affected, resident had potential to be at risk by this deficient practice. 3. The Maintenance Director has corrected the load test for the generator. Battery powered emergency lighting has been attached to the inside of the building attached to the 400 hall dining room. This was installed on 4/8/21 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool every day for 4 weeks, every week for 4 weeks and monthly for 3 months.	04/19/2021

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	Generators: Test generator under load" documentation dated 01/29/21 with the Executive Director and the Maintenance Director during record review from 2:30 p.m. to 3:45 p.m. on 03/16/21, the actual load percentage achieved for the January 2021 monthly load test for the diesel powered generator was not documented. Based on interview at the time of record review, the Maintenance Director stated he normally records the load percent for monthly load testing but agreed the January 2021 monthly load test percent achieved was not documented. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lighting was installed in 1 of 1 automatic transfer switch rooms. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect			

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	all residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the newly constructed automatic transfer switch room, which is attached to the outside of the building near the 400 Hall Dining Room, was not provided with battery-powered emergency lighting. Based on interview at the time of the observations, the Maintenance Director stated the room was newly constructed as part of the renovation to accommodate the vent unit beds and agreed the newly constructed automatic transfer switch room was not provided with battery-powered emergency lighting. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 05	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not			

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	155491	A. BUILDING 05 B. WING	03/16/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	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 99)			
	1. Based on observation, record review and interview; the facility failed to provide 1 of 1 oxygen transfilling rooms with adequate exhaust ventilation. NFPA 99, Section 9.3.7.5.1 states for the purposes of this section, the volume of fluid (gas and liquid) to be used in determining the ventilation requirements shall be the volume of the stored fluid when expanded to standard temperature and pressure (STP) of the largest single vessel in the enclosed space. NFPA 99, Section 9.3.7.5.3.2 states mechanical exhaust	K 0923	1. The allegation is that the facility neglected to post a sign indicating smoking is not permitted. Wall mounted electrical outlet box for two receptacles was installed 12 inches above the floor and second wall mounted electrical outlet box was installed 46 inches above floor in the 400 hall oxygen storage room and they were not protected.	04/19/2021

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	shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm). This deficient practice will affect all vent unit residents. Findings include: Based on review of the facility's proposed building plans approved by the Indiana Department of Health (IDOH) with the Plan Review Department Supervisor and lead reviewer on 03/18/21 from 12:15 p.m. to 12:30 p.m., the facility installed an 85 CFM exhaust fan. Based on an email received by the Lead Reviewer on 12/15/20 at 12:52 p.m., the largest vessel in the oxygen storage room will be 250 cubic feet. Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the oxygen storage room was equipped with a mechanical exhaust vent. Based on an interview with the Maintenance Director at the time of the observations, the oxygen storage room on the 400 unit will be used for transfilling of small portable units from large stationary liquid oxygen containers each containing 1,235 (STP) cubic feet of liquid oxygen. Based on an interview with the Maintenance Director at the time of the observations, he was concerned the oxygen storage room would not be large enough for all the required liquid oxygen needed for 14 vent residents. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases was marked with a		2. No residents were affected, residents had the potential to be at risk by this deficient practice. 3. See exhibit R. Submitted documents final agreed cylinder quantities and sizes with ISDH. Reviewer Jon Clifford for oxygen storage room HVAC upgrade design, subsequently approved, implemented and completed. Residents will primarily use oxygen concentrators located in each resident room. Oxygen storage room tanks (e-cylinders) are primarily used for resident mobility requirements (leaving resident room). Signage was purchased and placed accordingly. 425 oxy storage room is 64 sq. ft. (4) h cylinders racked requires min. 4 sq. ft. (28) e cylinders racked requires min. 7 sq. ft. (verticle), racked horizontal can be less than 7. Need total 11 sq. ft to store racked cylinders (less if e cylinders are racked wall mounted.) Facility will replenish storage as needed based on consumption/demand. E cylinders for mobility purposes. Ox concentrators primary vent source. Largest cylinder in room (h) is 250 ft3, 1 cfm per 5 ft3 required exhaust. 250/5=50cfm required. Room balanced at 85 cfm (more than required) Monitoring procedure ensure PoC is effective and that cited	

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	precautionary sign which includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room in the 400 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the oxygen storage and transfilling room in the 400 Hall was not posted with signs indicating smoking in the immediate area is not permitted. Based on interview at the time of the observations, the Maintenance Director stated the facility is a smoking facility, oxygen storage and transfilling will occur in the room and agreed the area was not posted with a sign indicating smoking is not permitted. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure wall mounted electrical fixtures in 1 of 1 oxygen storage and transfilling rooms were protected. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 5.1.3.3.2 (5) and 5.1.3.3.2 (10) both requires locations for central supply systems and the storage of positive-pressure gases to protect electrical devices from physical damage. A.5.1.3.3.2 (5) states electrical devices should be physically protected, such as by use of a protective barrier around the electrical devices, or by location of		deficiency remains corrected / in compliance: Passive and scheduled Maint. Dept inspections for proper operation. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool daily for 4 weeks, weekly for 4 weeks and monthly for 3 months. Passive and scheduled Maint. Dept inspections for proper operation.	

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	the electrical device such that it will avoid causing physical damage to the cylinders or containers. For example, the device could be located at or above 5 feet above finished floor or other location that will not allow the possibility of the cylinders or containers to come into contact with the electrical device as required by this section. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room in the 400 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, a wall mounted electrical outlet box for two receptacles was installed twelve inches above the floor and a second wall mounted electrical outlet box was installed 46 inches above the floor in the 400 Hall oxygen storage and transfilling room and were not protected. The wall mounted light switch for the room was also mounted less than 5 feet above the floor and was also not protected. The measurements were taken with a measuring tape. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned wall mounted electrical were not protected by a protective barrier and were less than 5 feet above the floor. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0927 SS=E	NFPA 101 Gas Equipment - Transfilling Cylinders			

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Bldg. 05	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 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 1 oxygen storage/transfer locations was provided with a sign indicating that transferring is occurring. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(3) states, the area is posted with signs indicating that transfilling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room in the 400 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, the oxygen storage and transfilling room was not equipped with a sign indicating that transferring of oxygen occurs in this location and that smoking in the immediate area is not permitted. Based on interview at the time of the observations, the Maintenance Director stated the facility is a smoking facility, oxygen transfilling will occur in the room and agreed the room was not posted	K 0927	1. The allegation is that the facility failed to have signage outside of the oxygen storage and transfilling room. And that smoking in the immediate area is not permitted. 2. No residents were affected but had the potential to be at risk by this deficient practice. 3. The Maintenance Director immediately ordered the signage and it was placed. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool daily for 4 weeks, then weekly for 4 weeks and monthly for 3 months.	04/19/2021

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	with the necessary signage. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 9999 Bldg. 05	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide smoke detectors in all resident sleeping rooms in the renovated 100 Hall, 200 Hall and 400 Hall in the East Building. This deficient practice could affect all residents in the East Building. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 10:40 a.m. to 2:30 p.m. on 03/16/21, all resident sleeping rooms in the renovated 100 Hall, 200 Hall and 400 Hall in the east building were not equipped with a smoke detector. Based on interview at the time of the observations, the Maintenance Director stated each room had been	K 9999	1. The allegation is that the facility failed to have each sleeping room on 100 hall, 200 hall and 400 hall equipped with a smoke alarm. 2. No resident was affected but residents had the potential to be at risk by the deficient practice. 3. The Maintenance Director immediately placed battery operated smoke detectors in all resident room. 4. To ensure compliance the Maintenance Director or Designee will be responsible to complete the QA monitoring tool daily Monday - Friday for 4 weeks, weekly for 4 weeks, and monthly for 3 months.	04/19/2021

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	equipped with a smoke detector but they were removed to paint the rooms and were not reinstalled and agreed each resident sleeping room in the renovated portions of the East Building were not equipped with a smoke detector. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(a)			