STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155322	A. BUILDING -- B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/15/24 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 At this Emergency Preparedness survey, Majestic Care of West Allen was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 96 and had a census of 81 at the time of this survey. Quality Review completed on 08/19/24	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/15/24 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 At this Life Safety Code survey, Majestic Care of West Allen was found not in compliance with Requirements for Participation in	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zach Krumwied	Executive Director	09/04/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and hard-wired smoke detectors in resident rooms 310-317. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 96 and had a census of 81 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of a detached garage used to store maintenance supplies and equipment. Quality Review completed on 08/19/24			
K 0353 SS=E Bldg. 01	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 _____			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 1 of over 60 rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states The distance from sprinklers to privacy curtains, freestanding partitions, room dividers, and similar obstructions in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Floor-mounted obstructions with a horizontal distance of more than thirty inches must maintain a minimum vertical distance below deflector of eighteen inches. This deficient practice could affect at least 10 residents, staff, and visitors in the memory care unit. Finding includes: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/15/2024 at 1:10 p.m., boxes located in the memory care facilitator's office on the memory care unit, was stacked on the floor and extended to within 18 inches of the deflector. Based on interview at the time of the observation, the Maintenance Director acknowledged boxes were	K 0353	K 353 What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -The boxes referenced were moved to ensure an 18 inch barrier How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All residents that reside in the facility have the potential to be affected by the alleged deficient practice. An 18-inch barrier will be maintained throughout the facility. What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur? -The Maintenance director was educated on or before 8/28/2024 regarding items maintaining an 18-inch barrier. How the corrective actions will be	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	stacked in the office which could cause sprinkler spray pattern obstruction. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place) -Upon completion of the initial education with the Maintenance Director, the Executive Director will monitor the effectiveness of the 18-inch barrier through rounds and provide outcomes to the QAPI committee on a monthly basis. Additional education will be provided annually.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1) Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the memory care unit staff closet was 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 manufacturer. (3) In a listed bracket approved for such purpose. (4) In a cabinet or wall recess. This deficient practice could affect at least 10 staff, visitors, and residents in the memory care unit.	K 0355	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -The ABC fire extinguisher referenced on located on the memory care unit was properly secured and located. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All fire extinguishers will be	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/15/2024 at 1:02 p.m., the ABC portable fire extinguisher located in the memory care unit staff closet was sitting on a sink. Based on interview at the time of observation, the Maintenance Director did not have prior knowledge the extinguisher was sitting on the sink and was not mounted. 2) Based on observation, the facility failed to ensure 1 of 2 portable fire extinguishers in the laundry room was maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. This deficient practice could affect laundry staff only. Findings include: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/15/2024 at 2:04 p.m., 1 of 2 ABC dry chemical portable fire extinguishers located in the laundry room was missing an inspection tag, a pull pin, and a tamper resistant seal, which could be evidence that the extinguisher had been used. Based on interview at the time of observation, the Maintenance Director stated he believed that when soiled laundry was handled near the extinguisher the tag, pin, and seal may have been incidentally removed. These findings were reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		secured and located properly in the facility. What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur? -The maintenance director was in-serviced on 8/28/24 the importance of maintaining all fire extinguishers in the proper location and secure arrangements. How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place) -The Maintenance Director will bring results of the rounds to the QAPI meeting monthly to discuss the QA team and monitor for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 49 resident room doors to the corridor was maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. This deficient practice could affect staff, visitors, and approximately 32 residents in the smoke compartment. Findings include: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/15/2024 at 1:48 p.m., the corridor door of resident room 111 did not close and latch when tested multiple times. This was confirmed by the Maintenance Director who attempted but failed to close and latch the door multiple times. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0363	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -The door located on the entry to room 111 was repaired to ensure that it latched anc closed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All residents that reside on halls 100 could be affected. All doors were inspected to ensure that they close and latch appropriately. What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur? -The Maintenance director will perform monthly audits for three months and annually thereafter to ensure compliance is maintained. How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place)	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			-The Maintenance Director will bring results of the audits to the QAPI meeting monthly to discuss the QA team and monitor for compliance. ="" p="">	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of over 30 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors	K 0511	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -The two GFCI receptacles identified as being defective or non-functional were repaired or replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All residents, visitors, and staff have the potential to affected by the alleged deficient practice. All GFCI receptacles will be maintained in working order. What measures will be put into	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can		place and what systematic changes will be made to ensure that the deficient will not recur? The Maintenance director will perform weekly audits for three months and annually thereafter to ensure compliance is maintained. How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place) -The Maintenance Director will bring results of the audits to the QAPI meeting monthly to discuss the QA team and monitor for compliance. ="" p="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect at least 10 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director on 08/15/24 during a tour of the facility from 12:42 p.m. to 2:28 p.m., 1.) one electric receptacle with a ground fault circuit interrupter (GFCI) within three feet of the sink in the bathroom of resident room 215 failed to function properly when tested. The GFCI tester indicated "bad ground" and would not trip when tested multiple times. 2.) one electric receptacle with a ground fault circuit interrupter (GFCI) within three feet of the sink in the therapy room failed to function properly when tested. The GFCI tester indicated "bad ground" and would not trip when tested multiple times. Based on interview at the time of observation the Maintenance Director advised he did not know that the GFCI should be tested and that he had never tested them. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to vary conditions at unexpected times during fire drills on first shift for 3 of 4 quarters and second shift for 3 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff, visitors and residents. Findings include: Based on records review and interview with the Maintenance Director on 08/15/24 from 9:28 a.m. to 12:40 p.m., the following fire drills were documented: a) A first shift fire drill in the second quarter on 06/13/24 at 9:00 a.m. b) A first shift fire drill in the third quarter on 09/21/23 at 8:30 a.m. c) A first shift fire drill in the fourth quarter on 11/4/23 at 9:10 a.m. d) A second shift fire drill in the first quarter on 03/29/24 at 3:30 p.m. e) A second shift fire drill in the second quarter on 05/18/24 at 4:30 p.m. f) A second shift fire drill in the third quarter on 08/11/23 at 4:25 p.m. Based on interview the Maintenance Director acknowledged the fire drills were conducted in the within the same 1-hour time frame for the first shift	K 0712	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -A fired drill was conducted prior to August 28th with a varied condition and time. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All residents, visitors, and staff have the potential to affected by the alleged deficient practice. Fire Drills will be conducted monthly with the signals and emergency action under varied conditions. What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur? -The Maintenance director will perform monthly audits for three months and annually thereafter to ensure compliance is maintained. How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place) -The Maintenance Director will bring results of the audits to the QAPI meeting monthly to discuss the QA team and monitor	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	as well as fire drills conducted during the second shift. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		for compliance. ="" p="">	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review and observation, the facility failure to ensure 1 of 1 portable space heaters was not used in the facility. This deficient practice could affect at least 5 residents, staff and visitors in the vicinity of the reception desk area office. Findings include: Based on observation with the Maintenance Director on 08/15/24 during a tour of the facility at 12:46 p.m., a portable space heater was located under the reception desk. Based on record review the facility policy prohibited the use of space heaters in the facility. Based on interview at the time of the observation, the Maintenance Director acknowledged a portable space heater was located under the reception desk, but stated he thought it was allowed because it was not plugged into the electrical receptacle.	K 0781	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -All Residents were identified as being affected by the deficient practice. The space heater was identified was removed from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All Residents were identified as being affected by the deficient practice. A facility-wide audit was	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		conducted to ensure that no portable space are present or utilized in the facility. What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur? -The Maintenance director will perform monthly audits for three months and annually thereafter to ensure compliance is maintained. How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place) -The Maintenance Director will bring results of the audits to the QAPI meeting monthly to discuss the QA team and monitor for compliance.	
K 0918 SS=F Bldg. 01	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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4	K 0918	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? -All Residents were identified as being affected by the deficient practice. A 36-month 4-hour test was conducted on the facility generator prior to August 28th, 2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All Residents were identified as being affected by the deficient practice.	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Maintenance Director from 9:28 a.m. to 12:40 p.m. on 08/15/24, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator for the main building was not available for review. Based on interview at the time of record review, the Maintenance Director stated the generator service vendor was scheduled within the next couple weeks to conduct the testing. At the time of record review the Maintenance Director attempted to acquire documentation form the generator service vendor for the last 36 month emergency generator test; however, no documentation was made available. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		A 36-month 4-hour generator test will be performed per regulation. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice will not recur? -The Maintenance director will perform annual audits to ensure that a 36-month 4-hour test is completed and recorded. How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place) -The Maintenance Director will bring results of the audits to the QAPI meeting monthly to discuss the QA team and monitor for compliance.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1) Based on observation, the facility failed to ensure 1 of 1 medical supply room flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation and interview with the Maintenance Director on 08/15/24 at 1:16 p.m., a surge protector was found powering a high-amperage refrigerator being used in the medical supply room in the 300 hall. Based on interview at time of observation the Maintenance Director confirmed the improper use of a surge	K 0920	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents and staff were noted as being affected by the alleged deficient practice. The high-amperage refrigerator was plugged into the wall on a dedicated outlet. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? -All residents and staff could be affected by the deficient practice.	08/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING 01 B. WING	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF WEST ALLEN	6050 S CR 800 E 92 FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	protector. 2. Based on observation and interview, the facility failed to ensure a power strip in 1 of 49 resident rooms met UL rating of 1363, 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice could affects staff, visitors and approximately 32 residents. Findings include: Based on observation and interview with the Maintenance Director during a tour of the facility on 08/15/2024 at 1:42 p.m., multiple electrical chargers were plugged into and supplied power by a power strip in resident room 101. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use and the label indicated it does not comply with the UL rating of 1363, 1363A or 60601-1. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		An audit was performed to ensure that any non-rated as 1363, 1363A, 60601-1 power strips are in use. What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur? -The Maintenance director will perform Weekly audits for three months and annually thereafter to ensure compliance is maintained. How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place) -The Maintenance Director will bring results of the audits to the QAPI meeting monthly to discuss the QA team and monitor for compliance. ="" p="">	