STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155446	B. W	NG		05/13/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NAA IEGTI	0.0405.05.15555	DOON DOINTE			ILKIE DR		
MAJESTI	C CARE OF JEFFE	ERSON POINTE		FORT	WAYNE, IN 46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)		(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
E 0000							
Bldg							
J	An Emergency Preparedness Survey was		E 00	000	2025 Life Safety POC		
		diana Department of Health in		700	Majestic Care of Jefferson Poi	nte	
	accordance with 42	-			The following plan of correction		
					constitutes the facilities allegate		
	Survey Date(s): 05/2	12/25 & 05/13/25			of compliance such that all alle		
					deficiencies cited have been o	-	
	Facility Number: 00	00476			be corrected by the date or da		
	Provider Number: 1				indicated. The statements made		
	AIM Number: 1002				on the plan of correction are no		
	7111171 (4111001: 1002	20070			an admission to and does not	J.	
	At this Emergency I	Preparedness Survey, Majestic			constitute an agreement with the		
		ointe was found in compliance		alleged deficiencies herein. To			
		eparedness Requirements for			remain in compliance with all	'	
		caid Participating Providers			State and Federal regulations,	the	
	and Suppliers, 42 Cl				facility has taken or will take th		
	and Suppliers, 42 C	1 K 403.73.			actions set forth in the followin		
	The facility has a ca	pacity of 145 and had a			plan of correction.	9	
	census of 68 at the t				Majestic Care of Jefferson Poi	nto	
	census of oo at the t	mie of tins survey.			request paper compliance for t		
	Quality Review con	unleted on 05/20/25			following Plan of Correction.	.iie	
	Quanty Review con	ipieted on 03/20/23			I lollowing Flatt of Correction.		
K 0000							l
1.0000							
Bldg. 01							
Biag. 01	A Life Safety Code	Recertification and State	K 0	000	2025 Life Safety POC		ı
	-	as conducted by the Indiana	KU	000	Majestic Care of Jefferson Poi	nto	
	-	th in accordance with 42 CFR			The following plan of correction		
	483.90(a).	th in accordance with 42 Cr K			constitutes the facilities allegate		
	403.70(a).				of compliance such that all alle		
	Survey Date(s): 05/2	12/25 & 05/13/25			deficiencies cited have been o	-	
	Survey Date(s). 05/	12/23 % 03/13/23			be corrected by the date or da		
	Facility Number: 00	00476			indicated. The statements made		
	Provider Number: 1				on the plan of correction are n		
	AIM Number: 1002				an admission to and does not	Ji	
	ATIVI INGILIUGI. 1002	70010				he	
	At this Life Safety	Code survey, Majestic Care of			constitute an agreement with t alleged deficiencies herein. To		
	•	s found not in compliance with			remain in compliance with all	'	
	Jefferson i onne was	5 round not in compilance with			Tomain in compliance with all		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

David Holbrook Executive Director 06/18/2025

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EKB921 Facility ID: 000476 If continuation sheet Page 1 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/13/2025
	PROVIDER OR SUPPLIER		5700 W	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BITTE
	Life Safety from Fir National Fire Protect Life Safety Code (L Care Occupancies at This one story facilimezzanine was detection and was facility has a fire all detection in corridor corridors and has be in the resident room of 145 and had a ce survey. All areas where the access were sprinkly facility services were	the and the 2012 edition of the extion Association (NFPA) 101, ISC) Chapter 19, Existing Health and 410 IAC 16.2. The with an upstairs mechanical extinct to be of Type V (111) as fully sprinklered. The extra system with smoke are and areas open to the extre operated smoke detector as. The facility has a capacity insus of 68 at the time of this expression of the extra system with smoke are sprinklered. All areas providing the sprinklered, except a shed rage and a garage used for except as the extra system.		State and Federal regulations facility has taken or will take to actions set forth in the following plan of correction. Majestic Care of Jefferson Porequest paper compliance for following Plan of Correction.	ne ng inte
K 0100 SS=E Bldg. 01	NFPA 101 General Requirem Based on observation failed to maintain lactoring coordinators on 1 of 1 Main Dimit 4.6.12.3 requires expositions to the public shall be either main		K 0100	K100 SS=E General Requirements The corrective actions that were accomplished for those residents to have been affect by from the practice are: The deficiency was corrected immediately by adding door closing coordinators. *see attached photo How other residents of the facility were identified to	ted

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 2 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

	of deficiencies (XI) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER 155446	A. BUILDING B. WING	01	COMPLETED 05/13/2025
	ROVIDER OR SUPPLIER C CARE OF JEFFERSON POINTE	5700 W	ADDRESS, CITY, STATE, ZIP COD /ILKIE DR WAYNE, IN 46804	
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0222	Based on observations with the Maintenance Director at 11:19 a.m. on 05/13/25, the east and west door sets to the Main Lounge were each equipped with latching hardware at the top of each door but the latching hardware for the east door in the east door set failed to latch into the door frame when tested to close multiple times. Each door in the door set was also equipped with a wall mounted magnetic holding device set to release the door to close with fire alarm system activation. Each door set was also equipped with an astragal but the door closing coordinator on the door frame had been removed. Based on interview at 11:19 a.m. on 05/13/25, the Maintenance Director agreed the east door failed to latch into the door frame and the closing coordinators had been removed which would not ensure the door with the astragal closed last when automatic closing. Based on observations with the Maintenance Director at 12:58 p.m. on 05/13/25, the north and south door sets to the Main Dining Room were equipped with a wall mounted magnetic holding device set to release the door to close with fire alarm system activation. Each door set was also equipped with an astragal but the door closing coordinator on the door frame had been removed. Based on interview at 12:58 p.m. on 05/13/25, the Maintenance Director agreed the closing coordinators had been removed which would not ensure the door with the astragal closed last when automatic closing. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		potentially be affected by the practice are: All residents have the potential to be affected by practice. The deficiency was corrected immediately by addit door closing coordinators. The facility has taken the following measures to ensure that the problem has been corrected and will not recur to the deficiency was corrected immediately by adding door closing coordinators. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qualities assurance program will be reviewed at the monthly QAPI meetings to ensure compliance. Date of compliance: June 6, 2025	re this ng e by: tty ut
SS=E	Egress Doors			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 3 of 35

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED
		155446	B. Wl	NG		05/13/	2025
NAME OF P	PROVIDER OR SUPPLIEI	r.			ADDRESS, CITY, STATE, ZIP COD		
	IC CARE OF JEFF				/ILKIE DR WAYNE, IN 46804		
(X4) ID	SIMMADV	STATEMENT OF DEFICIENCIE	I	ID	 I		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
Bldg. 01	REGULATORT OF	R LSC IDENTIFTING INFORMATION		IAU			DATE
Blug. 01	1 Deced on observe	ation and interview, the facility	$ _{K0}$	222	K222 SS-E Emmas Dagra		06/06/2025
		means of egress through 1 of	K.U.	222	K222 SS=E Egress Doors The corrective actions that		06/06/2025
		d exits was readily accessible				_	
		ut a clinical diagnosis requiring			were accomplished for thos residents to have been affect		
		measures. Doors within a					
		egress shall not be equipped			by from the practice are: The	e	
	-	that requires the use of a tool			deficiencies were corrected		
		ress side unless otherwise			immediately by removing the		
		Section 19.2.2.2.4. Door-locking			identified slide bolt lock and		
		be permitted in accordance			adding the security code to the	ie	
	_	•			doors. *see attached photo		
	with 19.2.2.2.5.2. This deficient practice could				How other residents of the		
	affect over 20 residents, staff and visitors if needing to exit the courtyard.				facility were identified to	_	
	needing to exit the	courtyard.			potentially be affected by th		
	E' 1' ' 1 1				practice are: All residents ha		
	Findings include:				the potential to be affected by		
	D 1 1	tal at the training			practice. The deficiencies we		
		ons with the Maintenance			corrected immediately by add	-	
	_	n. on 05/13/25, the exit door by			the security code to the doors	8	
		g Room was marked as a facility			The facility has taken the		
	_	gn. The door could be opened			following measures to ensu	re	
		at a keypad by the exit door			that the problem has been		
	_	n the door was not posted			corrected and will not recur	-	
		all is a secure wing for male			The deficiencies were correct	cted	
		clinical diagnosis requiring			immediately by adding the		
		measures. The discharge for			security code to the doors. T		
		a fenced courtyard which had			maintenance director or desig		
	-	n could also be opened by			will verify the door code is into		
		t code at a keypad by the exit			5x per week X1 month, then 3		
		o open the door was not			per week x2 months, then 1x	per	
	^	observations at 1:04 p.m. on			week x3 months to ensure		
		Dining Room by the main			ongoing compliance.		
	-	a door set which was marked			*see attached audit		
	-	th an exit sign. The door set			How will the corrective		
		entering a code at a keypad.			action(s) be monitored to		
	_	he door set was posted by the			ensure the deficient practice		
		lischarge for the Main Dining			will not recur, i.e., what qual	lity	
		is into the same courtyard as			assurance program will be p	out	
	the exit discharge f	or the 400 Hall. The Main			into place: Audits will be		
	Dining Room is no	t in an area of the facility which			reviewed at the monthly QAP	1	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	01	COMPL	ETED
		155446	B. W	ING		05/13	/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIE	R			ILKIE DR		
MAJEST	IC CARE OF JEFF	ERSON POINTE		FORT WAYNE, IN 46804			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ith a clinical diagnosis			meetings to ensure compliar		
		ed security measures. As a			Date of compliance: June 6	,	
	-	d is shared by residents with			2025		
	the clinical diagnosis to be in a secure area and residents without the clinical diagnosis to be in a secure area. Based on interview at 1:04 p.m. on						
		-					
	05/13/25, the Maintenance Director agreed the courtyard was a shared courtyard and agreed the						
	exit door code was not posted at the keypad for the courtyard gate to the public way.						
	are courry ard gate	to the public maj.					
	These findings wer	re reviewed with the Executive					
	Director and the Maintenance Director during the						
	exit conference.	5					
	3-1.19(b)						
	2. Based on observ	ration and interview, the facility					
		throoms in 1 of over 50 resident					
		re not equipped with locks					
		pened from the egress side.					
	-	5.1 states door leaves shall be					
	arranged to be open	ned readily from the egress					
	side. Locks, if pro	vided, shall not require the use					
	of a key, tool, or sp	pecial knowledge or effort for					
	operation from the	egress side. This deficient					
	practice could affect	ct one resident.					
	Findings include:						
	Rased on observati	ons with the Maintenance					
		.m. on 05/13/25, resident					
		I and Room 103 share a					
		sident sleeping room has an					
		athroom. Resident sleeping					
		ide bolt latching device affixed					
		the door which prohibits					
		from the bathroom if the slide					
		king position. Based on					
		a.m. on 05/13/25, the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 5 of 35

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/13/2025
	ROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0281 SS=E Bldg. 01	101 comes into Roca and causes problem. The intent of the slie egress from the bath Room 103 uses the resident in Room 10 the slide bolt did no readily opened from bathroom. These findings were Director and the Markett conference. 3-1.19(b) NFPA 101 Illumination of Mean and series was any single lighting of the area in darkness illumination shall be failure of any single in an illumination le in any designated and could affect over 20 needing to exit the findings include: Based on observation of the series of the markett conference and discharge for the markett conference and discharge for the markett conference and could affect over 20 needing to exit the findings include:	or stated the resident in Room om 103 through the bathroom is for the resident in Room 103. In the resident in Room 103 through the resident in Room 103. In the resident in Bathroom but to keep the 101 out of Room 103 but agreed it arrange the door to be in the egress side of the reviewed with the Executive content of the re	K 0281	K281 SS=E Illumination of means of egress The corrective actions that were accomplished for those residents to have been affect by from the practice are: The bulbs identified during survey replaced immediately by the facility. How other residents of the facility were identified to potentially be affected by the practice are: All residents had the potential to be affected by practice. The facility has taken the following measures to ensure that the problem has been corrected and will not recur the maintenance director or	eted e were e ve this

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155446	B. W	NG		05/13/	/2025
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					ILKIE DR		
MAJESTI	IC CARE OF JEFFE	ERSON POINTE		FORT	VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S DI AN OF CO			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		a.m. on 05/13/25, the			designee will inspect the lights	5x	
		tor agreed the aforementioned			per week X1 month, then 3x p		
		not arranged with the minimum			week x2 months, then 1x per	•	
	_	lighting fixtures (bulbs).			week x3 months to ensure		
	number of operation	ingining invares (suiss).			ongoing compliance.		
	These findings were reviewed with the Executive				*see attached audit		
	Director and the Maintenance Director during the				How will the corrective		
	exit conference.						
	exit conference.				action(s) be monitored to		
	2 1 10(b)				ensure the deficient practice		
	3.1-19(b)				will not recur, i.e., what quali	-	
					assurance program will be p	ut	
					into place: Audits will be		
					reviewed at the monthly QAPI		
					meetings to ensure complianc	e.	
					Audits will be reviewed at the		
					monthly QAPI meetings to ens	sure	
					compliance.		
					Date of compliance: June 6,		
					2025		
K 0200	NEDA 404						
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01	D 1 1	. 1:4 . 4 6 114	17.0	200			06/06/0005
		view and interview, the facility	K 0	300	K300 SS=F Protection - other	<u>r</u>	06/06/2025
	_	ventative maintenance for all			The corrective actions that		
		oke alarms in resident rooms			were accomplished for those		
		FPA 101 in 4.6.12.3 states			residents to have been affect		
		features obvious to the public,			by from the practice are: The	9	
		ne Code, shall be maintained.			maintenance director began		
	-	ice could affect over all			documenting the cleaning of the	те	
	residents, staff and	visitors.			smoke detectors monthly on		
					5/16/25.		
	Findings include:					ļ	
					How other residents of the	ļ	
		Direct Supply TELS Logbook			facility were identified to	ļ	
		etectors Test: Battery Operated			potentially be affected by the)	
		locumentation for the most			practice are: All residents have	∕e	
	recent twelve month	h period with the Maintenance			the potential to be affected by	this	
	Director at 2:35 p.n	n. on 05/12/25, battery operated			practice. The maintenance	ļ	
	smoke detector clea	ning documentation was not			director began documenting th	ne	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(x3) date survey completed 05/13/2025
	PROVIDER OR SUPPLIEI		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BATTE
	p.m. on 05/12/25, the facility tests the detectors in the resilve weekly basis, every exterior of the detecteaning documentareview. At 2:37 p.1 Director took the based on from the ceil: Manufacturer's doc smoke detector ind Model 0827 smoke detector weekly and monthly. Based on 05/12/25, the Main same type of batter installed in each resilvent.	he Maintenance Director stated battery operated smoke dent sleeping rooms on a time they are tested the etor is cleaned but agreed ation was not available for m. on 05/12/25, the Maintenance attery operated smoke detectoring in Room 101. Immentation affixed to the leated it was a First Alert detector and to test the did to clean the detector interview at 2:37 p.m. on tenance Director stated the y operated smoke detector is sident sleeping room.		cleaning of the smoke detector monthly on 5/16/25. The facility has taken the following measures to ensure that the problem has been corrected and will not recur to the maintenance director be documenting the cleaning of the smoke detectors monthly on 5/16/25. The ED or designee audit the monthly documentation of the smoke detector cleaning monthly x6 months. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qualical assurance program will be previewed at the monthly QAPI meetings to ensure compliance. Date of compliance: June 6, 2025	e by: gan ne will on d
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas	- Enclosure			
	failed to ensure 3 o as fuel-fired heater storage rooms/spac separated from othe partitions and doors or automatic closin	on and interview, the facility f over 18 hazardous areas such rooms and combustible es (over 50 square feet) were er spaces by smoke resistant s. Doors shall be self closing g in accordance with 7.2.1.8. ice could affect over 50 visitors.	K 0321	K321 SS=E Hazardous areas Enclosure The corrective actions that were accomplished for those residents to have been affect by from the practice are: A self-closing device was adde the door of room 211. *see photo. The hole in the wall next to the mezzanine furnace was correct and no longer exist. *See photo	eted ed to eted

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 8 of 35

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLET	TED
		155446	B. W	ING		05/13/20	025
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT	IO OADE OF IEEE	FROON ROINTE			ILKIE DR		
MAJEST	IC CARE OF JEFFE	ERSON POINTE		FORTV	VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OE CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1) Based on observa	ations with the Maintenance			A door handle was added to the	ne	
	Director at 10:51 a.	m. on 05/13/25, the corridor			door without a latching device		
		rage room by Room 211 was			which led to the kitchen by the	I	
	not self closing or automatic closing. The room was used for storage of combustible supplies.				machine. *see photo		
					A door was ordered to be place	ed:	
	Based on interview at 10:51 a.m. on 05/13/25, the				in between the kitchen and dry		
		for stated the room measured			storage room and will be insta		
		eet square and agreed and the			to compartmentalize the kitche		
	-	dialysis storage room by			and dry storage. The door wil	I	
		self closing or automatic			installed by the vendor upon	1 50	
	closing.	son crosing or automatic			receiving it.		
	crosing.				How other residents of the		
	2) Based on observa	ations with the Maintenance			facility were identified to		
	2) Based on observations with the Maintenance Director at 11:47 a.m. on 05/13/25, a ten inch by				potentially be affected by the		
		hole was cut in the wall of the			practice are: All residents have	I	
	_	room which exposed the			the potential to be affected by	I	
		netal grill was place over the			practice.	uns	
		anine contained three natural			A self-closing device was add	lod	
		Based on interview at 11:47			to the door of room 211.	ieu	
	-	ne Maintenance Director agreed			The hole in the wall next to the		
		ve inch square hole in the wall			mezzanine furnace was correct		
		rnace room exposed the			and no longer exist.	Jieu	
	adjoining attic.	mace room exposed the			A doorknob was installed on the	20	
	adjoining attic.					ic	
	3) Based on observe	ations with the Maintenance			door to the kitchen by the ice machine.		
	1	n. on 05/13/25, the door to the			A door was ordered to be place	her	
	-	nachine area in the Main			in between the kitchen and dry		
		not equipped with a positive			storage room and will be insta		
		atch the door into the door			to compartmentalize the kitche		
	_	as equipped with a thumb twist			· · · · · · · · · · · · · · · · · · ·	I	
		vice. The kitchen contained			and dry storage room. The do will be installed by the vendor		
		om for combustible supplies			-		
		pped with a self closing or			upon receiving it.		
		oor which made the storage			The facility has tales at the		
	_	tchen. A door frame and door			The facility has taken the		
		nstalled to separate the Main			following measures to ensur	е	
		the ice machine area outside			that the problem has been		
		door would not latch into the			corrected and will not recur	by:	
		not self closing or automatic			<u> </u>		
	closing. Based on i	nterview at 1:10 p.m. on			The maintenance director or		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet Page 9 of 35

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155446	B. W	ING		05/13/	2025
	PROVIDER OR SUPPLIEF			5700 W	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	05/13/25, the Maintenance Director stated the facility recently installed a door to the ice machine area to keep residents out of this area, the door installation had not been completed and agreed the door to the kitchen by the ice machine area of the Main Dining Room was not equipped with a positive latching device to latch the door into the door frame.				designee will audit for the wall being intact near Mezzanine furnace and room 211 door clot 1x per week x1 month, then per month x 5 months.	osure	
	_	e reviewed with the Executive aintenance Director during the			How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be pinto place: Audits will be reviewed at the monthly QAPI meetings to ensure compliance	ity ut	
					Date of compliance: June 6, 2025		
K 0324 SS=D Bldg. 01	failed to install the accordance with the Section 9.2.3 states equipment shall be NFPA 96, Standard Fire Protection of COperations. NFPA states kitchen range equipped with a driedges. The tray shanneeded to collect grain into an enclose	on and interview, the facility kitchen range hood system in requirements of LSC 9.2.3. commercial cooking installed in accordance with for Ventilation Control and commercial Cooking 96, 2011 edition, Section 6.2.4.1 hood system filters shall be p tray beneath their lower II be kept to the minimum size ease and shall be pitched to ed metal container having a ing 1 gal (3.785 L). This	K 0	324	K324 SS=D Cooking facilitie The corrective actions that were accomplished for those residents to have been affect by from the practice are: A d tray was ordered by the vendo and installed. *see photo How other residents of the facility were identified to potentially be affected by the practice are: All residents hav the potential to be affected by practice. A drip tray was orde and installed	e ted drip or e e e	06/06/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 10 of 35

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPL	
		155446	B. WING			05/13/	2025
NAME OF P	PROVIDER OR SUPPLIER	2			DDRESS, CITY, STATE, ZIP COD		
MAJESTI	IC CARE OF JEFFE	ERSON POINTE			/AYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	•	ould affect over two kitchen			The facility has taken the		
	staff and visitors.				following measures to ensur	е	
	Findings include:				that the problem has been corrected and will not recur I	-	
	Rosed on observative	ons with the Maintenance			Vendor will include inspection	OT	
		1. on 05/13/25, two of two			the drip tray in all future inspections. The maintenance	ے	
	designated locations underneath the kitchen				director or designee will inspe		
	range hood system			the presence of the drip tray: 5			
	enclosed metal container for grease to drain into.				per week X1 month, then 3x p		
	The two designated locations for a grease container each had a one half inch in diameter hole in the drip tray beneath the system filters with one of the locations having an affixed bracket				week x2 months, then 1x per		
					week x3 months to ensure		
					ongoing compliance.		
					How will the corrective		
	-	ner but no container was			action(s) be monitored to		
	-	the two designated locations.			ensure the deficient practice		
	Based on interview	at the time of the aintenance Director stated the			will not recur, i.e., what quali	-	
		nave never had a container for			assurance program will be p into place: Audits will be	ut	
		and agreed each of the two			reviewed at the monthly QAPI		
	-	s underneath the kitchen			meetings to ensure compliance		
	-	drip tray were missing an			Date of compliance: June 6,	о. 	
		tainer for grease to drain into.			2025		
	These findings were	e reviewed with the Executive					
	Director and the Ma	aintenance Director during the					
	exit conference.						
	3.1-19(b)						
K 0345	NFPA 101						
SS=C	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance	.					
	1. Based on observa	ation and interview, the facility	K 0345	5	K345 SS=C Fire alarm system	<u>n – </u>	07/02/2025
		ne fire alarm system to ensure			testing and maintenance		
		time and date information in			The corrective actions that		
		e requirements of NFPA 101,			were accomplished for those		
	· ·	ons 19.3.4 and 9.6 and NFPA 72,			residents to have been affect		
		ons 14.1 and 14.1.1. This			by from the practice are: The		
	deficient practice co	ould affect all residents, staff	1		fire panel vendor was contacted	ed to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 11 of 35

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETE	
		155446	B. WI	NG	_	05/13/202	25
			1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			ILKIE DR		
MAJEST	IC CARE OF JEFFE	ERSON POINTE		FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CC	OMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	and visitors.				make the corrections in the fire	e	
					panel to reflect the correct tim	e	
	Findings include:				and date. *See photo. The		
					vendor, SafeCare, will comple		
		ons with the Maintenance			duct detector test July 2, 2025		
	Director at 11:57 a.m. on 05/13/25, the remote fire				and then annually.		
	alarm control panel in the foyer by resident				How other residents of the		
	sleeping Room 501 read the time of day as 10:47				facility were identified to		
		Based on observations with the			potentially be affected by the		
		tor at 12:14 p.m. on 05/13/25,			practice are: All residents have		
		ol panel in the Electrical Room			the potential to be affected by		
		the time of day as 11:04 a.m. at			practice. The fire panel vendo		
	-	on interview at 12:14 p.m. on			corrected the date and time in		
	· ·	tenance Director agreed the fire			fire panel. The vendor, SafeC		
		s for the facility displayed the			will complete a duct detector t		
	incorrect time of da	y.			July 2, 2025 and then annually	/.	
					The facility has taken the		
	_	e reviewed with the Executive			following measures to ensur	е	
		aintenance Director during the			that the problem has been		
	exit conference.				corrected and will not recur	-	
					The fire panel check of correct		
	3.1-19(b)				date and time will be added to	the	
	4 D 1 1				monthly fire extinguisher		
		review, observation and			inspections by the maintenance	e	
	· ·	ty failed to ensure 1 of 1 fire			director to ensure		
	-	maintained in accordance with			compliance. The vendor,	,	
		3 requires a fire alarm system to			SafeCare, will complete a duc		
		and maintained in accordance			detector test July 2, 2025 and		
		ional Electrical Code and NFPA			then annually.		
		larm Code. NFPA 72, 2010			How will the corrective		
		4.5 requires testing shall be			action(s) be monitored to		
	-	dance with Table 14.4.5 Testing 14.4.5 at 15.(a) states fire alarm			ensure the deficient practice		
	-	rs shall be functional tested			will not recur, i.e., what quali	-	
	-	4.4.1.2.1.1 states when an			assurance program will be p	ut	
	•	added it shall be functionally			into place: Audits will be		
	_	6.2.4 states a record of all			reviewed at the monthly QAPI		
		and maintenance shall be			meetings to ensure compliance Date of compliance: July 2,		
		les all applicable information					
	-	14.6.2.4. This deficient			2025		
	L LANDONAL III ETYNIC						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025
	PROVIDER OR SUPPLIEF		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	1 -	t over 10 residents, staff and ity of the mezzanine in the 500			
	inspection contractor. Inspection" documed 11/27/24 with the Mp.m. on 05/12/25, fidevice inspections of month period did not facility. Based on or Maintenance Direct two duct detectors of ductwork in the attimezzanine. Based 05/13/25, the Maintelephone the fire all contractor who state replacement duct do 2025 and testing do reports but agreed to available for review.	the fire alarm system or's "Fire Alarm System entation dated 05/10/24 and Maintenance Director at 2:45 are alarm system initiating for the most recent twelve of include duct detectors in the observations with the error at 11:44 a.m. on 05/13/25, were noted installed in HVAC or which adjoined the on interview at 11:44 a.m. on tenance Director contacted by larm system inspection ed the duct detectors were effectors installed in February cumentation should be on the esting documentation was not of the ereviewed with the Executive enterence Director during the			
	exit conference. 3.1-19(b)				
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System	- Installation			
	failed to maintain the over 100 sprinkler l NFPA 13, Standard	ation and interview, the facility ne ceiling construction in 2 of ocations in accordance with for the Installation of Sprinkler , 2010 edition, Section 6.2.7.1	K 0351	K351 SS=E Sprinkler System installation The corrective actions that were accomplished for those residents to have been affective.	se

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 13 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446			(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/13/2025	
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD		
				VILKIE DR		
MAJEST	C CARE OF JEFFE	ERSON POINTE	FORT	WAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	heons, or other devices used		by from the practice are: The	I	
		space around a sprinkler shall		escutcheons that was identified	ed	
	·	be listed for use around a		missing near room 201 were		
	-	cient practice could affect over		replaced. *See photo.		
	20 residents, staff a	nd visitors.		Maintenance director or design		
				will provide training to all staf		
	Findings include:			NFPA13 including the 18" rule		
				The shelf storage in the priva		
		ons with the Maintenance		room on 100 hall was remove		
		m. on 05/13/25, the ceiling		immediately allowing greater		
	_	ocation in the corridor outside		18 inches of space between t	he	
		ssing escutcheon which		shelf and the ceiling.		
	exposed the space above. Based on observations			How other residents of the		
	_	3/25, the sprinkler installed on		facility were identified to		
	-	the Main Lounge near the attic		potentially be affected by th		
		o missing its escutcheon.		practice are: All residents ha		
		at 10:46 a.m. on 05/13/25 and		the potential to be affected by		
	_	3/25, the Maintenance Director		practice. The escutcheon that		
		locations were missing its		was identified as missing out		
	escutcheon.			of room 201 has been replace		
				*See photo. The shelf storag		
		e reviewed with the Executive		the private room on 100 hall v		
		aintenance Director during the		removed immediately allowin	_	
	exit conference.			greater than 18 inches of spa	I	
				between the shelf and the ce	iling.	
	3.1-19(b)			The facility has taken the		
				following measures to ensu	re	
		ation and interview, the facility		that the problem has been		
		spray pattern for sprinkler		corrected and will not recur	-	
		ructed in 1 of 1 storage rooms		The maintenance director or		
		ference Room in accordance		designee will inspect the store	_	
		NFPA 13, 2010 edition, Section		shelf in private room on 100 h		
	•	elers shall be located so as to		ensure ongoing compliance:		
		ons to discharge as defined in		per week X1 month, then 3x	•	
		Section 8.5.5.3 or additional		week x2 months, then 1x per		
		provided to ensure adequate		week x3 months to ensure		
		ard. Sections 8.5.5.2 and 8.5.5.3		ongoing compliance.		
	_	nuous or noncontinuous		Maintenance Director or desi		
		an or equal to 18 inches below		will do a whole house audit to		
	the sprinkler deflect	tor or in a horizontal plane		ensure that all escutcheons a	ire	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet

Page 14 of 35

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025
	PROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	that prevent the spradeveloping. This do over 20 residents, stof the 100 Hall Confirmation Findings include: Based on observation Director at 10:33 axinside the Private roce Conference Room beighteen inches of the installed in the room a.m. on 05/13/25, the shelf storage was with deflector in the room. These findings were	ons with the Maintenance m. on 05/13/25, shelf storage oom inside the 100 Hall by Room 122 was within the ceiling mounted sprinkler m. Based on interview at 10:33 the Maintenance Director agreed tithin 18 inches of the sprinkler m. the not reviewed with the and the Maintenance Director		intact: 1x per week x1 month, then 2x per month x 2months, then 1x per month x3 months. *see attachments Maintenance director or design will provide training to all staff of NFPA13 including the 18" rule. *see attachment How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be previewed at the monthly QAPI meetings to ensure compliance. Date of compliance: June 6, 2025	re: ty ut
K 0353 SS=F Bldg. 01	Based on record interview; the facili hydrostatic flush wa automatic sprinkler internally inspected	review, observation and ty failed to ensure a full as performed for 1 of 4 piping systems that were as required by NFPA 25, 2011 d for the Inspection, Testing	K 0353	K353 SS=F Sprinkler system Maintenance and testing The corrective actions that were accomplished for those residents to have been affect	
	and Maintenance of Systems in Chapter Section 14.3.2 requi- for internal obstruct that could cause obs 14.3.3, states if an o	Water-Based Fire Protection 14, Obstruction Prevention. ires systems shall be examined ions where conditions exist structed piping. Section obstruction investigation ce of sufficient material to		by from the practice are: The laundry room sprinkler her was cleaned immediately, the Maintenance Director will inspet the sprinkler heads and escutcheons throughout the facility to check for cleanliness and serviceability 1x per quarte	ect

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 15 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	OMB NO. 0936-039		
			1		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>01</u>	05/13/2025	
		155446	B. WING		05/13/2025	
NAME OF I	PROVIDER OR SUPPLIER		STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	FROVIDER OR SUFFLIER	X.	5700 W	VILKIE DR		
MAJEST	IC CARE OF JEFF	ERSON POINTE	FORT \	WAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DE COMPTENDE DE CO	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	obstruct pipe or spr	rinklers, a complete flushing		The fire system maintenance		
	program shall be co	onducted by qualified		vendor was contacted and a f	lush	
		14.3.1 states if the condition		of the dry system will be		
	_	eted or the condition is one		completed July 2, 2025.		
	that could result in	obstruction of piping despite		SafeCare will complete quarte	erly	
		ng procedures that have been		inspections ongoing and will	´	
		em shall be examined internally		provide appropriate document	tation	
		ery 5 years. This deficient		of the inspections.		
		et all residents, staff and		How other residents of the		
	visitors in the facili			facility were identified to		
				potentially be affected by the		
	Findings include:			practice are: All residents have		
				the potential to be affected by		
	Based on review of	the sprinkler system		practice.		
		or's "Sprinkler: Five Year		The facility has taken the		
	_	ction" documentation dated		following measures to ensur	e l	
		Maintenance Director at 12:15		that the problem has been		
	p.m. on 05/12/25, tl	he "Inspection Results" for dry		corrected and will not recur	bv:	
	_	s listed as " System needs				
		interview at 12:15 p.m. on		The laundry room sprinkler he	ad	
		tenance Director stated no		was cleaned immediately , the	I	
		or additional internal pipe		Maintenance Director will insp		
	inspection documen	ntation on or after 12/15/20 was		the sprinkler heads and		
	available for review	v. The Maintenance Director		escutcheons throughout the		
	stated a flush was n	not performed because the		facility to check for cleanliness	s	
	Corporate Office st	ated it didn't fail the inspection		and serviceability 1x per quart	I	
	-	mendation to flush. Based on		The fire system maintenance		
	observations with the	he Maintenance Director at		vendor was contacted and a f	lush	
	10:04 a.m. on 05/13	3/25, the sprinkler system		of the dry system will be		
	inspection contracto	or had affixed an internal pipe		completed July 2, 2025.		
	inspection sticker to	o the wet and dry sprinkler		SafeCare will complete quarte	erly	
	systems in the 100	Hall sprinkler riser room but the		inspections ongoing and will		
	sticker did not state	e flushing was performed and		provide appropriate document	ation	
	did not state the res	sults of the 12/15/20 internal		of the inspections.		
	pipe inspection. Ba	ased on observations with the		How will the corrective		
	Maintenance Direct	tor at 11:57 a.m. on 05/13/25,		action(s) be monitored to		
	the sprinkler systen	n inspection contractor had		ensure the deficient practice		
	affixed an internal j	pipe inspection sticker to the		will not recur, i.e., what qual		
	wet and dry sprinkl	er systems in the 500 Hall		assurance program will be p	=	
	sprinkler riser room	n but the sticker did not state		into place: Audits will be		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
	flushing was perfor results of the 12/15. These findings were Director and the Ma exit conference.	med and did not state the /20 internal pipe inspection. e reviewed with the Executive aintenance Director during the		reviewed at the monthly QAI meetings to ensure compliar Date of compliance: July 2, 2025	PI nce.	
	interview, the facili automatic sprinkler for internal obstruct that could cause obs NFPA 25, 2011 Edi Inspection, Testing Water-Based Fire P 14.2.1. Section 14.2 in 14.2.1.1 and 14.2 branch line condition years by opening a of one main and by the end of one brancinspecting for the p	review, observation and ty failed to ensure 1 of 4 piping systems was examined tions where conditions exist structed piping as required by ition, the Standards for the and Maintenance of trotection Systems, Section 2.1 states, "except as discussed 2.1.4 an inspection of piping and ons shall be conducted every 5 flushing connection at the end removing a sprinkler toward ch line for the purpose of resence of foreign organic and This deficient practice affects and visitors.				
	inspection contractor. Internal Pipe Inspect 12/15/20 with the Mp.m. on 05/12/25, the sprinkler systems have inspection within the Internal pipe inspect facility's fourth spring for review. Based of	the sprinkler system or's "Sprinkler: Five Year etion" documentation dated Maintenance Director at 12:15 nree of the facility's four ad a documented internal pipe ne most recent five year period. tion documentation for the nkler system was not available on interview at 12:15 p.m. on tenance Director stated no				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

76

If continuation sheet Page 17 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION	IDI	ENTIFICATION NUMBER 55446	ILDING	01	COMPL 05/13/	ETED
NAME OF PROVIDER OR SU		SON POINTE	5700 W	DDRESS, CITY, STATE, ZIP COD ILKIE DR VAYNE, IN 46804		
(X4) ID SUM PREFIX (EACH DE	MARY STA	ATEMENT OF DEFICIENCIE MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
additional sp inspection do the facility's for review. It Maintenance the sprinkler affixed an interview and dry seprinkler rises the results of Based on observation Director at 1 system inspecting internal pipe sprinkler system on but the the 12/15/20. These finding Director and exit conference 3.1-19(b). 3. Based on interview; the documentation components of 4 quarters, maintained in for the Inspection.	constraints of the serial pipe o	stem internal pipe ion on or after 12/15/20 for inkler system was available observations with the at 10:04 a.m. on 05/13/25, spection contractor had e inspection sticker to the systems in the 100 Hall at the sticker did not state is/20 internal pipe inspection. with the Maintenance on 05/13/25, the sprinkler tractor had affixed an a sticker to the wet and dry to 500 Hall sprinkler riser d not state the results of ipe inspection. Eviewed with the Executive tenance Director during the inspected and tested for 1 ter systems shall be properly nee with NFPA 25, Standard ting, and Maintenance of tection Systems, 2011	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE TO THE	DATE
Edition. NFI waterflow ala quarterly to v damage. NF mechanical v not limited to quarterly. N	PA 25, Securify they perify they PA 25, Securify they waterflow a p, water materials.	ection 5,3.5 requires that es shall be inspected are free of physical ection 5.3.3.1 requires the alarm devices including, but notor gongs, shall be tested Section 4.3.1 requires records aspections, tests, and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 18 of 35

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446		ILDING	nstruction 01	(X3) DATE : COMPL 05/13/	ETED
	PROVIDER OR SUPPLIER			5700 W	DDRESS, CITY, STATE, ZIP COD ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	be made available to jurisdiction upon re- requires that record performed (e.g., ins- the organization that results, and the date	system components and shall to the authority having quest. NFPA, 25 Section 4.3.2 is shall indicate the procedure pection, test, or maintenance), it performed the work, the interpretation to the staff and visitors in the facility.					
	Based on review of inspection contractor Inspection-Equipme 05/01/24, 08/22/24, Maintenance Direct first quarter (Januar sprinkler inspection for review. It was I documented quarter and testing during the second quarter 202: p.m. on 05/12/25, the sprinkler contract the inspection but defined and agreed no first of March) 2025 sprink was available for resulting birector at 10:04 and system inspection of tags to the wet and 100 Hall sprinkler resulting to the sprinkler of the spr	the sprinkler system or's "Sprinkler: Report of ent" documentation dated 11/15/24 and 04/29/25 with the or at 2:45 p.m. on 05/12/25, no y, February, March) 2025 documentation was available 65 days in between ely sprinkler system inspection the fourth quarter 2024 and the 5. Based on interview at 2:45 the Maintenance Director stated ector came 02/24/25 to perform tid sprinkler repairs instead equarter (January, February, eller inspection documentation view at the time of the survey. The survey ons with the Maintenance on 05/13/25, the sprinkler ontractor had affixed hanging dry sprinkler systems in the tiser room which did not					
	inspection. Based of Maintenance Direct the sprinkler system affixed hanging tag systems in the 500 l	on observations with the for at 11:57 a.m. on 05/13/25, an inspection contractor had so to the wet and dry sprinkler Hall sprinkler riser room which ent a first quarter 2025					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 19 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155446	ì í	UILDING	01	COMPL 05/13/	ETED
	PROVIDER OR SUPPLIER			5700 W	NDDRESS, CITY, STATE, ZIP COD ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	sprinkler system instance of Wasser Systems, 2011 Edit sprinklers shall not be free of corrosion physical damage; ar correct orientation (sidewall). Furthern that shows signs of replaced: (1) Leakage (2) Corrosion (3) Physical Damag (4) Loss of fluid in element (5) Loading (6) Painting unless manufacturer. In lieu of replacing dust, it is permitted compressed air or be equipment does not	ereviewed with the Executive aintenance Director during the red with lint were replaced or once with NFPA 25. NFPA 25, pection, Testing, and ter-Based Fire Protection ion, Section 5.2.1.1.1 states show signs of leakage; shall and shall be installed in the feeg., up-right, pendent, or nore, at 5.2.1.1.2 any sprinkler any of the following shall be the glass bulb heat responsive sprinklers that are loaded with to clean sprinklers with y a vacuum provided that the					
	Based on observation	ons with the Maintenance					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 20 of 35

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIE		5700 W	ADDRESS, CITY, STATE, ZIP COD /ILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
K 0362 SS=E Bldg. 01	mounted sprinkler Laundry Room was interview at 1:30 p. Maintenance Direc regularly clean spri agreed the aforeme loaded with lint. These findings wer Director and the M exit conference. 3.1-19(b) NFPA 101 Corridors - Consti Based on observati failed to ensure cor compartments in th resist the transfer o practice could affect visitors in the vicin machine in the mai Findings include: Based on observati Director at 12:53 p holes were noted in ice machine/water lobby which would smoke. Based on i 05/13/25, the Main fountain had been i was replaced with the	on and interview, the facility ridor walls in 1 of 8 smoke the facility were constructed to f smoke. This deficient of over 10 residents, staff and the ity of ice machine/water in entrance lobby. ons with the Maintenance the corridor wall behind the machine in the main entrance in not resist the transfer of interview at 12:53 p.m. on tenance Director stated a water in place at that location but it the ice machine/water machine is in the wall would not resist	K 0362	K362 SS=E Corridors – Construction of walls The corrective actions that were accomplished for those residents to have been affect by from the practice are: The holes behind the ice machine it the main lobby were fixed May 2025 *please see photos. How other residents of the facility were identified to potentially be affected by the practice are: All residents hav the potential to be affected by practice. The holes behind the machine in the main lobby were fixed May 15, 2025. The facility has taken the following measures to ensure that the problem has been corrected and will not recur to Maintenance Director will insp	ted e in / 15, e re this e ice re e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 21 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155446 B. WING 05/13/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5700 WILKIE DR MAJESTIC CARE OF JEFFERSON POINTE FORT WAYNE. IN 46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE These findings were reviewed with the Executive walls for damage daily during Director and the Maintenance Director during the maintenance rounds. In addition, exit conference. items that are identified will be corrected immediately by the 3.1-19(b)Maintenance Director. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Audits will be reviewed at the monthly QAPI meetings to ensure compliance. Date of compliance: June 6, 2025 K 0363 **NFPA 101** SS=E Corridor - Doors Bldg. 01 Based on observation and interview, the facility K 0363 K363 SS=E Corridor - doors 06/06/2025 failed to ensure 2 of over 50 corridor doors had no The corrective actions that impediment to closing and latching into the door were accomplished for those frame and would resist the passage of smoke. residents to have been affected This deficient practice could affect over 20 by from the practice are: The residents, staff and visitors. defective latch on door of room 321 was replaced immediately. Findings include: The jar that was used to keep the Business office door open was Based on observations with the Maintenance removed immediately. Director at 12:38 p.m. on 05/13/25, the corridor How other residents of the door to resident sleeping Room 321 failed to latch facility were identified to into the door frame when tested to close multiple potentially be affected by the times. The latching mechanism on the door failed practice are: All residents have to protrude into the latching plate on the door the potential to be affected by this frame. Based on interview at 12:38 p.m. on practice. The defective latch on 05/13/25, the Maintenance Director agreed the door of room 321 was replaced corridor door to resident sleeping Room 321 failed immediately. The jar that was to latch into the door frame when tested to close used to keep the Business office multiple times. Based on observations with the door open was removed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 22 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	A. BUILDING <u>01</u> COMPL			ETED
		155446	B. WING	B. WING 05/13/			2025
			<u> </u>				
NAME OF P	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD		
					ILKIE DR		
MAJEST	IC CARE OF JEFF	ERSON POINTE		FORT W	VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
	`			I	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		tor at 12:56 p.m. on 05/13/25,			immediately.		
		the Business Office behind			The facility has taken the		
	-	at the main entrance lobby was			following measures to ensure	е	
		open position with a jar			that the problem has been		
	-	up against the door. Based on			corrected and will not recur l	oy:	
		p.m. on 05/13/25, the			The defective latch on door of	of	
		tor agreed the corridor door to			room 321 was replaced		
		was propped in the fully open			immediately. The jar that was		
	position with a jar j	placed on the floor up against			used to keep the Business offi	ce	
	the door.				door open was removed		
					immediately. The maintenance	е	
	These findings wer	e reviewed with the Executive			director or designee will inspec	ct all	
	Director and the M	aintenance Director during the			facility doors to ensure proper		
	exit conference.				latching; 5x per week X1 mont		
					then 3x per week x2 months, t		
	3.1-19(b)				1x per week x3 months to ens		
	()				ongoing compliance. *see		
					attachment		
					How will the corrective		
					action(s) be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali		
					assurance program will be p	-	
						ut	
					into place: Audits will be		
					reviewed at the monthly QAPI		
					meetings to ensure complianc	e.	
					Date of compliance: June 6, 2025		
K 0544	NEDA 404						
K 0511	NFPA 101						
SS=E	Utilities - Gas and	l Electric					
Bldg. 01							
		review, observation and	K 051	11	K511 SS= E Utilities – Gas a	<u>nd</u>	06/06/2025
		ity failed to ensure that the			<u>Electric</u>		
		or has a reliable source of fuel			The corrective actions that		
		the requirements of NFPA 101,			were accomplished for those	•	
	2012 edition, Section	on 19.5.1.1, 9.1, 9.1.3.1 and			residents to have been affect	ted	
	NFPA 110, 2010 E	dition, Section 5.1. LSC Section			by from the practice are: An		
	9.1.3.1 states emerg	gency generators shall be			updated letter with the correct		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 23 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155446	B. W	ING		05/13/2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ILKIE DR		
MAJESTI	IC CARE OF JEFFE	ERSON POINTE			WAYNE, IN 46804		
			1		,	l	`
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5	
PREFIX	`	CY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLE	
TAG		R LSC IDENTIFYING INFORMATION I maintained in accordance	-	TAG			2
	· ·	andard for Emergency and			date was obtained from NIPS	50/	
	· ·				gas provider re: the facility's		
		tems, 2010 Edition. Section			natural gas fuel-fired emergen	СУ	
		owing energy sources shall be			generator. *See attachment.	- h	
		d for the emergency power			The receptacles behind the lo	-	
	supply (EPS):	n nyoduota ot atmosphanis			ice machine were equipped w		
		m products at atmospheric			cover plate and the holes in th		
	pressure	over one (liquid or			wall were repaired. *See phot	0.	
		eum gas (liquid or vapor			The electrical outlet in the	_	
	withdrawal)	atia ana			conference room bathroom wa		
	(3) Natural or synth	_			replaced with a GFI outlet. *S	ee	
	-	el 1 installations in locations			photo.		
	-	ty of interruption of off-site			The Maintenance Director		
		n, on-site storage of an			inspected the entire facility to		
		arce sufficient to allow full			ensure that GFIs are present	as	
	-	to be delivered for the class			appropriate. *see attachment		
	-	equired, with the provision for		How other residents of the			
		from the primary energy source			facility were identified to		
	to the alternate ener				potentially be affected by the		
		es examples of probability of			practice are: All residents have		
	-	nclude the following:			the potential to be affected by		
	-	amage, or a demonstrated			practice. An updated letter wi		
		This deficient practice could			the correct date was obtained	from	
	affect all residents,	staff and visitors.			NIPSCO/ gas provider re: the		
	Findings 1 1 1				facility's natural gas fuel-fired		
	Findings include:				emergency generator. The		
	D1 1	since solds the Maint			receptacles behind the lobby i		
		view with the Maintenance			machine were equipped with a		
		n. on 05/12/25, the natural gas			cover plate and the holes in th		
	_	n the off-site fuel supplier for			wall were repaired. The outle		
	-	gas fuel-fired emergency			the conference room bathroor		
	-	ated. As a result, the date of			and behind the lobby ice mach		
		f the reliability of fuel supply			were replaced with GFI outlets	S.	
		d not be established. Based			The facility has taken the		
		5 p.m. on 05/12/25, the			following measures to ensur	e	
		for stated additional natural			that the problem has been		
		documentation from the			corrected and will not recur	-	
		r was not available for review			An updated letter with the cor		
	-	bility letter was not dated.			date was obtained from NIPS	CO/	
	Based on observation	ons with the Maintenance			gas provider re: the facility's		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 24 of 35

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155446	B. W.	ING		05/13/	/2025
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/ILKIE DR		
MAJEST	IC CARE OF JEFF	ERSON POINTE			WAYNE, IN 46804		
	10 0/11/2 01 02/1	ENGOITI GIITIE		I OIKI V	1		T
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		.m. on 05/13/25, the facility has			natural gas fuel-fired emerger	-	
	_	el-fired emergency generator			generator. The receptacles b	ehind	
		building on the north side of			the lobby ice machine were		
		ufacturer's nameplate			equipped with a cover plate a	nd	
		ixed to the generator indicated it			the holes in the wall were		
	was rated at 150 k	W.			repaired. The outlet in the		
					conference room bathroom ar		
	3.1-19(b)				behind the lobby ice machine		
					replaced with GFI outlets. Go	ıng	
		vation and interview, the facility			forward all GFI outlets will be		
		electrical wiring in the facility			audited bi-annually by the		
		a safe operating condition. LSC			Maintenancve Director or		
	*	lities comply with Section 9.1.			designee.		
	^	s electrical wiring and equipment			How will the corrective		
		FPA 70, National Electrical Code.			action(s) be monitored to		
		lition, Article 314 states exposed			ensure the deficient practice		
		ptacles shall be enclosed so			will not recur, i.e., what qual	-	
	_	minals are not exposed to			assurance program will be p	ut	
		cient practice could affect 20			into place: Audits will be	_	
	residents, staff and	l visitors in the north hall.			reviewed at the monthly QAPI		
	F' 1' ' 1 1				meetings to ensure compliance	æ.	
	Findings include:				Date of compliance: June 6,		
	Dagad - : -1	ions with the Maintenance			2025		
	_	o.m. on 05/13/25, the two					
		ed on the corridor wall behind ater machine near the main					
		s not confined within an outlet					
	•	he receptacles were not					
		over plate. Based on interview					
		5/13/25, the Maintenance					
	_	e receptacles were not enclosed					
	_	terminals are not exposed to					
	contact.	terminals are not exposed to					
	These findings we	re reviewed with the Executive					
		Iaintenance Director during the					
	exit conference.	=					
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 25 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/13/2025	
	PROVIDER OR SUPPLIE		5700 W	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION
	3. Based on observe failed to ensure 1 or provided with group (GFCI) protection 19.5.1.1 requires under the comply with NF NFPA 70, NEC 20 Circuit-Interrupter states, ground-fault personnel shall be 210.8(A) through (circuit-interrupter accessible location (B) Other Than D single-phase, 15-a installed in the location through (8) shall he circuit-interrupter (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to not readily accessible be permitted with 426.28 or 427 Exception No. 2 to only, where the consupervision ensure are involved, an as conductor programs shall be permitted outlets used to supcreate a greater has	ration and interview, the facility of over 50 wet locations were and fault circuit interrupter against electric shock. LSC tilities comply with Section 9.1. The electrical wiring and equipment and PA 70, National Electrical Code. The Interruption for Personnel, to circuit-interruption for provided as required in a readily and 20-ampere receptacles ations specified in 210.8(B)(1) are ground-fault protection for personnel. The ground-fault protection for provided as required in a readily and 20-ampere receptacles ations specified in 210.8(B)(1) are ground-fault protection for personnel.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 26 of 35

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			5700 V	STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE COMPLETION			
	1.8 m (6 ft.) of the Exception No. 1 to receptacles used to removal of power whazard shall be per GFCI protection. Exception No. 2 to patient bed location care areas of health covered under 210. not be required. (6) Indoor wet loca (7) Locker rooms what it is a service electrical diagnostic tools, or portable ligused. NFPA 70, 517-20 Where the wet location to interrupter (GFCI) reduce the contact relectrical insulation. This deficient praction the restroom in the restroom	sceptacles are installed within outside edge of the sink. (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without (5): For receptacles located in as of general care or critical care facilities other than those 8(B)(1), GFCI protection shall tions with associated showering the bays, and similar areas where the equipment, electrical hand ghting equipment are to be Wet Locations, requires all the equipment within the area of the ground-fault circuit protection. Note: Moisture can resistance of the body, and are is more subject to failure. The ince could affect one staff while the Conference Room by Room ons with the Maintenance m. on 05/13/25, the two sees installed in the wall mounted from the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the protection of the sink in the restroom in the sink in the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 27 of 35

06/19/2025 PRINTED: FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155446 B. WING 05/13/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 5700 WILKIE DR MAJESTIC CARE OF JEFFERSON POINTE FORT WAYNE. IN 46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Based on interview at 10:39 a.m. on 05/13/25. the Maintenance Director agreed the aforementioned electrical receptacles were not provided with ground fault circuit interrupters (GFCI). These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)K 0918 **NFPA 101** SS=F Electrical Systems - Essential Electric Syste Bldg. 01 1. Based on record review, observation and K 0918 K918 SS=F Electrical systems -06/06/2025 interview; the facility failed to document a **Essential electric system** complete written record of monthly generator load The corrective actions that testing for 1 month of the most recent 12 month were accomplished for those period in accordance with NFPA 110, Standard for residents to have been affected Emergency and Standby Power Systems. NFPA by from the practice are: The 110, 2010 Edition, Section 8.4.1 states Emergency facility is unable to correct past Power Supply Systems (EPSS), including all deficient practice. The appurtenant components shall be inspected maintenance director or designee weekly and exercised under load at least monthly. will perform and document the Section 8.4.2.4 states spark-ignited generator sets generator load bank test monthly shall be exercised at least once a month with the per regulations. The generator available EPSS load for 30 minutes or until the battery will be tested monthly by water temperature and the oil pressure have the maintenance director. stabilized. NFPA 99, 2012 Edition, Section 6.4.4.2 How other residents of the requires a written record of inspection, facility were identified to performance, exercising period, and repairs for the potentially be affected by the generator to be regularly maintained and available practice are: All residents have for inspection by the authority having the potential to be affected by this jurisdiction. This deficient practice could affect all practice. The maintenance residents, staff and visitors. director or designee will perform and document the generator load Findings include: bank test monthly per

FORM CMS-2567(02-99) Previous Versions Obsolete

Based on review of Direct Supply TELS Logbook

Documentation "Emergency Power Generators:

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

regulations. The generator battery

will be tested monthly by the

maintenance director.

Page 28 of 35

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		B. WING 05/13/2025			05/13/2025		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIER	8			ILKIE DR		
MAJESTI	IC CARE OF JEFFE	ERSON POINTE			WAYNE, IN 46804		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE				ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX			
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1710		ler Load" documentation with		1110	The facility has taken the	DATE	
		rector at 2:07 p.m. on 05/12/25,			following measures to ensur	. <u>.</u>	
		g documentation for 04/30/25			that the problem has been		
	-	e under load" as "25" minutes.			corrected and will not recur	hv	
		at 2:07 p.m. on 05/12/25, the			The maintenance director or	·	
		tor stated he may have keyed			designee will perform the		
		ne but agreed the 04/30/25			generator load bank test mont	thly	
	-	g documentation indicated			per regulations. The generate	-	
		generator load testing			battery will be tested monthly		
	documentation for A	-			the maintenance director. The	•	
		inimum of 30 minutes. Based			or designee will audit the mon		
	on observations wit	h the Maintenance Director at			results 1x per month x6 month	-	
	11:13 a.m. on 05/13	3/25, the facility has one			ensure compliance. *See		
		nergency generator located			attached audit		
	-	g on the north side of the			How will the corrective		
	property. Manufact	turer's nameplate			action(s) be monitored to		
	documentation affix	xed to the generator indicated it			ensure the deficient practice		
	was rated at 150 kW	V.			will not recur, i.e., what quali		
					assurance program will be p	ut	
	These findings were	e reviewed with the Executive			into place: Audits will be		
	Director and the Ma	aintenance Director during the			reviewed at the monthly QAPI		
	exit conference.				meetings to ensure compliance	e.	
					Date of compliance: June 6,		
	3.1-19(b)				2025		
		review, observation and					
		ty failed to ensure a complete					
		onthly testing of emergency					
		atteries was maintained for 10					
		recent 12 month period in					
		FPA 99. Chapter 6-4.4.1.3 of					
	-	uires batteries for on-site					
	-	maintained in accordance with					
		dition, Standard for Emergency Systems. NFPA 110, Section					
		aintenance of lead-acid					
		de the monthly testing and					
	-	shall be gravity. Battery					
	_	shall be permitted in lieu of					
	uie testing of specif	ic gravity when applicable or			1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 29 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
		eficient practice could affect all			5.112
	Findings include:				
	contractor's "General documentation date the Maintenance Description that results of emeral battery electrolyte Based on interview Maintenance Direct emergency general documentation for period was not avan observations with 11:13 a.m. on 05/1 natural-gas fired en outside the buildin property. Based on 05/13/25, the Main not mess with batter generator contractor.	f the generator inspection rator: Level 2 Service" ed 06/28/24 and 11/21/24 with prector at 2:45 p.m. on 05/12/25, gency generator starting testing was listed as passing. If at 2:45 p.m. on 05/12/25, the stor stated additional for starting battery testing the most recent twelve month ilable for review. Based on the Maintenance Director at 3/25, the facility has one mergency generator located g on the north side of the interview at 11:13 a.m. on attenance Director stated he does ery testing and only the por tests the starting battery. The reviewed with the Executive tenance Director during the exit			
K 0921 SS=F Bldg. 01	Maintenanc Based on observatifailed to conduct the maintain complete for all Patient Care (PCREE). NFPA	nent - Testing and on and interview, the facility he required maintenance and documentation of inspections Related Electrical Equipment 199, Health Care Facilities Code, ons 10.3 and 10.5 states the	K 0921	K921 SS=F Electrical equipment – testing and maintenance The corrective actions that were accomplished for thos residents to have been affect	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 30 of 35

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONS			(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPLETED 05/13/2025	
		155446	B. Wl	ING		05/13/2025	
NAME OF T	DOMINED OF CURPLIES			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER	C		5700 W	/ILKIE DR		
MAJEST	IC CARE OF JEFFE	ERSON POINTE		FORT \	WAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETIO	DΝ
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		esistance, leakage current, and			by from the practice are: Th		
		for fixed and portable PCREE			facility is unable to correct pas	st	
		uired in 10.3. Testing intervals			deficient practice. The		
		policies and protocols. All			maintenance director or desig		
	_	ient care rooms is tested in			will document all PCREE chec	cks	
		.3.5.4 or 10.3.6 before being put			before equipment is put into		
		er any repair or modification.			service, and after any repair o	r	
	1	ing of several electrical			modification per regulations.		
		rates compliance with NFPA			How other residents of the		
		stem. Service manuals,			facility were identified to		
		ocedures provided by the			potentially be affected by the		
		de information as required by			practice are: All residents have		
		onsidered in the development			the potential to be affected by	this	
		ectrical equipment maintenance.			practice. The maintenance		
		nt instructions and maintenance			director or designee will docu	ment	
	I -	available, and safety labels			all PCREE checks before		
	_	rating instructions on the			equipment is put into service,		
		e. A record of electrical			after any repair or modification	n per	
		pairs, and modifications is			regulations.		
	_	riod of time to demonstrate			The facility has taken the		
	1 -	rdance with the facility's			following measures to ensur	е	
	- '	esponsible for the testing,			that the problem has been		
		e of electrical appliances			corrected and will not recur		
		training. This deficient			The maintenance director or		
	practice affects all r	residents in the facility.			designee will document all		
					PCREE checks before equipn		
	Findings include:				is put into service, and after a	ny	
					repair or modification per		
		ons with the Maintenance			regulations. The ED or design	nee	
		m. on 05/13/25, the resident bed			will audit the PCREE		
		n electric bed. Based on			documentation log results 1x	per	
		i.m. on 05/13/25, the			month x6 months to ensure		
		for stated all resident beds in			compliance.		
	I -	cric beds, some PCREE in the			How will the corrective		
		by a contractor who may test			action(s) be monitored to		
		greed PCREE testing			ensure the deficient practice		
		not available for review.			will not recur, i.e., what qual	-	
		ons with the Maintenance			assurance program will be p	ut	
		m. on 05/13/25, the resident bed			into place: Audits will be		
	and a nebulizer wer	e noted in resident sleeping			reviewed at the monthly QAPI	1	

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING 01 B. WING		(X3) DATE (COMPL 05/13/	ETED	
	PROVIDER OR SUPPLIER			5700 W	ADDRESS, CITY, STATE, ZIP COD IILKIE DR NAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Room 114, the resid Room 123 was an e	lent bed in resident sleeping lectric bed and an oxygen so noted in the room.			meetings to ensure compliance Date of compliance: June 6, 2025	e.	
		e reviewed with the Executive sintenance Director during the					
	3.1-19(b)						
K 0923 SS=E Bldg. 01	Storag	Cylinder and Container	K 0	923	K923 SS=F Gas equipment -	-	06/06/2025
	failed to ensure 1 of was in accordance of Facilities Code. NF 11.3.1 states storage equal to or greater to comply with 5.1.3.3 5.1.3.3.2 states, if in positive-pressure gause interior finishes combustible materia ceilings, and doors resistant rating. The affect over 40 residucinity of the oxygroom by the shower Findings include: Based on observation at 10:25 a.m. on 05 containers and sever were stored in the or room by the shower ceiling consisted of observed next to the	into and interview, the facility is 2 indoor oxygen storage areas with NFPA 99, Health Care if PA 99, 2012 Edition, Section is for nonflammable gases than 3000 cubic feet shall is 2 and 5.1.3.3.3. Section adoors, storage locations of isses shall be constructed and of noncombustible or limited als such that all walls, floor, are of minimum 1-hour fire is deficient practice could tents, staff and visitors in the en storage and transfilling is room by Room 117. The ons with Maintenance Director (13/25, six liquid oxygen in 'E' type oxygen cylinders axygen storage and transfilling froom by Room 117. The one layer of drywall as adjustable skirt type is reiling mounted sprinkler in	K 0	923	Cylinder and container stora. The corrective actions that were accomplished for those residents to have been affect by from the practice are: The liquid oxygen tanks were remoter from the therapy gym immedia and placed in the oxygen room West Hall. A drywall vendor we contacted and scheduled to inderwall in oxygen room ceiling increase fire resistance to a minimum of 1 hour. *See attached vendor invoice How other residents of the facility were identified to potentially be affected by the practice are: All residents have the potential to be affected by practice. The liquid oxygen tall were removed from the therap gym immediately and placed in the oxygen room on West Hall drywall vendor was contacted scheduled to install drywall in oxygen room ceiling to increase.	eted eted eted etely n on etely n stall to etel etels etel etels etel etels etel etel	06/06/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 32 of 35

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155446	B. W	ING		05/13/2025	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIER	t .			/ILKIE DR		
MAJESTIC CARE OF JEFFERSON POINTE					WAYNE, IN 46804		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE					,		
(X4) ID				ID PROVIDER'S PLAN OF CORRECTION DEFETY (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	+	TAG		DATE	
		n interview at 10:25 a.m. on			fire resistance to a minimum of	DT 'I	
		tenance Director agreed the			hour.		
	_	consisted of one layer of			The facility has taken the		
	1 -	not enclose the room with a			following measures to ensur	e	
	minimum 1-hour fii	re resistant rating.			that the problem has been	.	
	Those findings	a ravious d with the Everentine			corrected and will not recur	-	
	1	e reviewed with the Executive nintenance Director during the			The liquid oxygen tanks were		
	exit conference.	annenance Director during the			removed from the therapy gyr		
	exit conference.				immediately and placed in the		
	2.1.10(1)				oxygen room on West Hall. T		
	3.1-19(b)				Maintenance Director or designate will reeducate all staff related		
	2. Based on observation and interview, the facility					10	
		f 2 cylinders of nonflammable		the proper storage of oxygen			
		en were properly secured from	cylinders. A drywall vendor was contacted and scheduled to install				
		oor oxygen storage areas.			drywall in oxygen room ceiling		
	_	are Facilities Code, 2012			increase fire resistance to a	, 10	
		3.2 states storage for			minimum of 1 hour.		
		s greater than 8.5 cubic meters			How will the corrective		
	_	t less than 85 cubic meters			action(s) be monitored to		
		nall 11.3.2.1 through 11.3.2.3.			ensure the deficient practice	,	
		11.3.3.2 states precautions in			will not recur, i.e., what qual		
		specified in 11.3.3.1 shall be in			assurance program will be p	-	
	•	.6.2. Section 11.6.2.3(11) states			into place: The Maintenance		
		ers shall be properly chained			Director or designee will reed	ucate	
		oper cylinder stand or cart.			all staff related to the proper	-	
		ice could affect one staff in the			storage of oxygen cylinders.	*See	
	_	m by the Therapy Entrance			attachment		
	near the Therapy G				Date of compliance: June 6,		
]				2025		
	Findings include:						
	Based on observation	ons with Maintenance Director					
	at 11:34 a.m. on 05/	/13/25, two liquid oxygen					
		'E' type oxygen cylinders were					
	stored in the oxyger	n storage room by the Therapy					
	Entrance near the T	herapy Gym. One of the two					
		nders in the room were not					
	stored in a rack, cha	ained or otherwise secured					
	from falling in a pro	oper cylinder stand or cart. A					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921 Facility ID: 000476

If continuation sheet Page 33 of 35

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/13/2025
	PROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0927 SS=E Bldg. 01	intended to be used falling but the rest of The other oxygen of secured in a cylinder 11:34 a.m. on 05/13 agreed one of the two room was not proper supported in a proper suppor	to secure to the wall was to secure the cylinder from of the chain was on the floor. ylinder in the room was r cart. Based on interview at /25, the Maintenance Director /0 oxygen cylinders in the rly chained, stored, secured or er cylinder stand or cart. Previewed with the Executive eintenance Director during the Transfilling Cylinders iew, observation and ty failed to ensure 1 of 1 locations was in accordance Ith Care Facilities Code. NFPA ection 11.5.2.3.1(1) states, focur in) a designated area portion of a facility wherein examined, or treated by a fire ex-resistive construction d and was provided with a indicating that smoking in the ot permitted. Section the area is mechanically 5.2.3.1(3) states the transfilling as shall be posted with a sign filling is occurring. This ould affect over 40 residents, the vicinity of the oxygen ing room by the shower room	K 0927	K927 SS=E Gas equipment: Transferring cylinders The corrective actions that were accomplished for those residents to have been affect by from the practice are: A "No Smoking" sign was placed the oxygen room door. *See photo. The ceiling mounted exhaust fan was replaced. *Sephoto How other residents of the facility were identified to potentially be affected by the practice are: All residents had the potential to be affected by practice. A "No Smoking" sign was placed on the oxygen rood door. *See photo. The ceiling mounted exhaust fan was replaced. *See photo	e eted d on Gee e ve ve this n om

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EKB921

Facility ID: 000476

If continuation sheet

Page 34 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/13/2025	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE			5700 W	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
IAU	Based on review of documentation with 12:45 p.m. on 05/12 and staff smoking i location. Based on Maintenance Direct liquid oxygen contatoxygen cylinders with storage and transfill by Room 117. The of drywall as obsertype escutcheon for in the room. Magn door did not state is only that transfilling signage other than a door or in the area. exhaust fan was insimited was not operable. It a.m. on 05/13/25, the transfilling occurs is signage is intended side of the door what agreed the ceiling for layer of drywall, the signage for the room the immediate area.	If the facility's smoking policy in the Maintenance Director at 2/25, the facility allows resident in a designated outdoor observations with tor at 10:25 a.m. on 05/13/25, six ainers and seven 'E' type were stored in the oxygen ling room by the shower room a ceiling consisted of one layer wed next to the adjustable skirt of the ceiling mounted sprinkler etic signage on the back of the moking was not allowed and g was occurring. No other the room location was on the In addition, a ceiling mounted stalled in the room but the fan Based on interview at 10:25 the Maintenance Director stated in the room, the magnetic to be moved to the corridor en transfilling occurs and for the room consisted of one to fan was not in operation and me did not include smoking in its not permitted.	IAG	The facility has taken the following measures to ensure that the problem has been corrected and will not recur. The maintenance director or designee will inspect the oxygroom door for the presence or "No Smoking" sign; 5x per week x3 months, then 3x per week x3 months to ensure ongoing compliance. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be reviewed at the monthly QAP meetings to ensure compliance. Date of compliance: June 6, 2025	by: gen f a eek 62	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EKB921 Facility ID: 000476 If continuation sheet Page 35 of 35