STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING -- B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date(s): 05/12/25 & 05/13/25 Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870 At this Emergency Preparedness Survey, Majestic Care of Jefferson Pointe was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 145 and had a census of 68 at the time of this survey. Quality Review completed on 05/20/25	E 0000	**2025 Life Safety POC** Majestic Care of Jefferson Pointe The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The statements made on the plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction. Majestic Care of Jefferson Pointe request paper compliance for the following Plan of Correction.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date(s): 05/12/25 & 05/13/25 Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870 At this Life Safety Code survey, Majestic Care of Jefferson Pointe was found not in compliance with	K 0000	**2025 Life Safety POC** Majestic Care of Jefferson Pointe The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The statements made on the plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Holbrook	Executive Director	06/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with an upstairs mechanical mezzanine was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors and has battery operated smoke detector in the resident rooms. The facility has a capacity of 145 and had a census of 68 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage. Quality Review completed on 05/20/25		State and Federal regulations, the facility has taken or will take the actions set forth in the following plan of correction. Majestic Care of Jefferson Pointe request paper compliance for the following Plan of Correction.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to maintain latching hardware and door closing coordinators on 1 of 1 Main Lounges and on 1 of 1 Main Dining Rooms per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents. staff and visitors. Findings include:	K 0100	**K100 SS=E General Requirements** **The corrective actions that were accomplished for those residents to have been affected 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**	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 this practice. The deficiency was corrected immediately by adding door closing coordinators. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** 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 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 0222 SS=E	NFPA 101 Egress Doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 outdoor courtyard exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the courtyard. Findings include: Based on observations with the Maintenance Director at 1:04 p.m. on 05/13/25, the exit door by the 400 Hall Dining Room was marked as a facility exit with an exit sign. The door could be opened by entering a code at a keypad by the exit door but the code to open the door was not posted because the 400 Hall is a secure wing for male residents with the clinical diagnosis requiring specialized security measures. The discharge for the exit door is into a fenced courtyard which had one exit gate which could also be opened by entering a four digit code at a keypad by the exit door but the code to open the door was not posted. Based on observations at 1:04 p.m. on 05/13/25, the Main Dining Room by the main entrance lobby had a door set which was marked as a facility exit with an exit sign. The door set could be opened by entering a code at a keypad. The code to open the door set was posted by the keypad. The exit discharge for the Main Dining Room exit door set is into the same courtyard as the exit discharge for the 400 Hall. The Main Dining Room is not in an area of the facility which	K 0222	**K222 SS=E Egress Doors** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The deficiencies were corrected immediately by removing the identified slide bolt lock and adding the security code to the doors. *see attached photo **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 this practice. The deficiencies were corrected immediately by adding the security code to the doors **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The deficiencies were corrected immediately by adding the security code to the doors. The maintenance director or designee will verify the door code is intact; 5x per week X1 month, then 3x per week x2 months, then 1x per week x3 months to ensure ongoing compliance. *see attached audit **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	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	houses residents with a clinical diagnosis requiring specialized security measures. As a result, the courtyard is shared by residents with 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. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3-1.19(b) 2. Based on observation and interview, the facility failed to ensure bathrooms in 1 of over 50 resident sleeping rooms were not equipped with locks which cannot be opened from the egress side. LSC Section 7.2.1.5.1 states door leaves shall be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of a key, tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect one resident. Findings include: Based on observations with the Maintenance Director at 10:11 a.m. on 05/13/25, resident sleeping Room 101 and Room 103 share a bathroom. Each resident sleeping room has an entry door to the bathroom. Resident sleeping Room 103 had a slide bolt latching device affixed to the room side of the door which prohibits access to the room from the bathroom if the slide bolt was in the locking position. Based on interview at 10:11 a.m. on 05/13/25, the		meetings to ensure compliance. **Date of compliance: June 6, 2025**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Director stated the resident in Room 101 comes into Room 103 through the bathroom and causes problems for the resident in Room 103. The intent of the slide bolt was not to prohibit egress from the bathroom when the resident in Room 103 uses the bathroom but to keep the resident in Room 101 out of Room 103 but agreed the slide bolt did not arrange the door to be readily opened from the egress side of the bathroom. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3-1.19(b)			
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Based on observation and interview, the facility failed to ensure egress lighting for 1 of 10 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the main lounge. Findings include: Based on observations with the Maintenance Director at 11:14 a.m. on 05/13/25, the exit discharge for the main lounge exit door was equipped with two separate lighting fixtures each with one light bulb socket for the fixture but one of the two light bulbs was burnt out. Based on	K 0281	**K281 SS=E Illumination of means of egress** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The bulbs identified during survey were replaced immediately by the facility. **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 this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by the** maintenance director or	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview at 11:14 a.m. on 05/13/25, the Maintenance Director agreed the aforementioned exit discharge was not arranged with the minimum number of operable lighting fixtures (bulbs). These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		designee will inspect the lights 5x per week X1 month, then 3x per week x2 months, then 1x per week x3 months to ensure ongoing compliance. *see attached audit **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. Audits will be reviewed at the monthly QAPI meetings to ensure compliance. **Date of compliance: June 6, 2025**	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on record review and interview, the facility failed to ensure preventative maintenance for all battery operated smoke alarms in resident rooms was performed. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect over all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Detectors Test: Battery Operated Smoke Detectors" documentation for the most recent twelve month period with the Maintenance Director at 2:35 p.m. on 05/12/25, battery operated smoke detector cleaning documentation was not	K 0300	**K300 SS=F Protection - other** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The maintenance director began documenting the cleaning of the smoke detectors monthly on 5/16/25. **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 this practice. The maintenance director began documenting the	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	available for review. Based on interview at 2:35 p.m. on 05/12/25, the Maintenance Director stated the facility tests the battery operated smoke detectors in the resident sleeping rooms on a weekly basis, every time they are tested the exterior of the detector is cleaned but agreed cleaning documentation was not available for review. At 2:37 p.m. on 05/12/25, the Maintenance Director took the battery operated smoke detector down from the ceiling in Room 101. Manufacturer's documentation affixed to the smoke detector indicated it was a First Alert Model 0827 smoke detector and to test the detector weekly and to to clean the detector monthly. Based on interview at 2:37 p.m. on 05/12/25, the Maintenance Director stated the same type of battery operated smoke detector is installed in each resident sleeping room. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		cleaning of the smoke detectors monthly on 5/16/25. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The maintenance director began documenting the cleaning of the smoke detectors monthly on 5/16/25. The ED or designee will 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 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 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 3 of over 18 hazardous areas such as fuel-fired heater rooms and combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 50 residents, staff and visitors. Findings include:	K 0321	**K321 SS=E Hazardous areas - Enclosure** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** A self-closing device was added to the door of room 211. *see photo. The hole in the wall next to the mezzanine furnace was corrected and no longer exist. *See photo	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1) Based on observations with the Maintenance Director at 10:51 a.m. on 05/13/25, the corridor door to dialysis storage room by Room 211 was not self closing or automatic closing. The room was used for storage of combustible supplies. Based on interview at 10:51 a.m. on 05/13/25, the Maintenance Director stated the room measured ten feet by twelve feet square and agreed and the corridor door to the dialysis storage room by Room 211 was not self closing or automatic closing. 2) Based on observations with the Maintenance Director at 11:47 a.m. on 05/13/25, a ten inch by twelve inch square hole was cut in the wall of the mezzanine furnace room which exposed the adjoining attic. A metal grill was place over the opening. The mezzanine contained three natural gas fired furnaces. Based on interview at 11:47 a.m. on 05/13/25, the Maintenance Director agreed the ten inch by twelve inch square hole in the wall of the mezzanine furnace room exposed the adjoining attic. 3) Based on observations with the Maintenance Director at 1:10 p.m. on 05/13/25, the door to the kitchen by the ice machine area in the Main Dining Room was not equipped with a positive latching device to latch the door into the door frame. The door was equipped with a thumb twist deadbolt locking device. The kitchen contained one large storage room for combustible supplies which was not equipped with a self closing or automatic closing door which made the storage room open to the kitchen. A door frame and door had recently been installed to separate the Main Dining Room from the ice machine area outside the kitchen but the door would not latch into the door frame and was not self closing or automatic closing. Based on interview at 1:10 p.m. on		A door handle was added to the door without a latching device, which led to the kitchen by the ice machine. *see photo A door was ordered to be placed in between the kitchen and dry storage room and will be installed to compartmentalize the kitchen and dry storage. The door will be installed by the vendor upon receiving it. **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 this practice. A self-closing device was added to the door of room 211. The hole in the wall next to the mezzanine furnace was corrected and no longer exist. A doorknob was installed on the door to the kitchen by the ice machine. A door was ordered to be placed in between the kitchen and dry storage room and will be installed to compartmentalize the kitchen and dry storage room. The door will be installed by the vendor upon receiving it. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The maintenance director or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(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. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		designee will audit for the wall being intact near Mezzanine furnace and room 211 door closure 1x per week x1 month, then 1x per month x 5 months. **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 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This	K 0324	**K324 SS=D Cooking facilities** **The corrective actions that were accomplished for those residents to have been affected by from the practice are**: A drip tray was ordered by the vendor and installed. *see photo **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 this practice. A drip tray was ordered and installed.	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	deficient practice could affect over two kitchen staff and visitors. Findings include: Based on observations with the Maintenance Director at 1:23 p.m. on 05/13/25, two of two designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. 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 for holding a container but no container was present for each of the two designated locations. Based on interview at the time of the observations, the Maintenance Director stated the drip tray locations have never had a container for grease to drain into and agreed each of the two designated locations underneath the kitchen range hood system drip tray were missing an enclosed metal container for grease to drain into. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		**The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Vendor will include inspection of the drip tray in all future inspections. The maintenance director or designee will inspect for the presence of the drip tray: 5x per week X1 month, then 3x per week x2 months, then 1x 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 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 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101, 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72, 2010 edition, Sections 14.1 and 14.1.1. This deficient practice could affect all residents, staff	K 0345	**K345 SS=C Fire alarm system – testing and maintenance** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The fire panel vendor was contacted to	07/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and visitors. Findings include: Based on observations with the Maintenance Director at 11:57 a.m. on 05/13/25, the remote fire alarm control panel in the foyer by resident sleeping Room 501 read the time of day as 10:47 a.m. at 11:57 a.m. Based on observations with the Maintenance Director at 12:14 p.m. on 05/13/25, the fire alarm control panel in the Electrical Room by Room 512 read the time of day as 11:04 a.m. at 12:14 p.m. Based on interview at 12:14 p.m. on 05/13/25, the Maintenance Director agreed the fire alarm system panels for the facility displayed the incorrect time of day. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Table 14.4.5 at 15.(a) states fire alarm system duct detectors shall be functional tested annually. Section 14.4.1.2.1.1 states when an initiating device is added it shall be functionally tested. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient		make the corrections in the fire panel to reflect the correct time and date. *See photo. The vendor, SafeCare, will complete a duct detector test July 2, 2025 and then annually. **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 this practice. The fire panel vendor corrected the date and time in the fire panel. The vendor, SafeCare, will complete a duct detector test July 2, 2025 and then annually. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The fire panel check of correct date and time will be added to the monthly fire extinguisher inspections by the maintenance director to ensure compliance. The vendor, SafeCare, will complete a duct detector test July 2, 2025 and then annually. **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: July 2, 2025**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	practice could affect over 10 residents, staff and visitors in the vicinity of the mezzanine in the 500 Hall. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 05/10/24 and 11/27/24 with the Maintenance Director at 2:45 p.m. on 05/12/25, fire alarm system initiating device inspections for the most recent twelve month period did not include duct detectors in the facility. Based on observations with the Maintenance Director at 11:44 a.m. on 05/13/25, two duct detectors were noted installed in HVAC ductwork in the attic which adjoined the mezzanine. Based on interview at 11:44 a.m. on 05/13/25, the Maintenance Director contacted by telephone the fire alarm system inspection contractor who stated the duct detectors were replacement duct detectors installed in February 2025 and testing documentation should be on the reports but agreed testing documentation was not available for review. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of over 100 sprinkler locations in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 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 affected**	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director at 10:46 a.m. on 05/13/25, the ceiling mounted sprinkler location in the corridor outside Room 201 had a missing escutcheon which exposed the space above. Based on observations at 1:45 p.m. on 05/13/25, the sprinkler installed on the ceiling beam in the Main Lounge near the attic access door was also missing its escutcheon. Based on interview at 10:46 a.m. on 05/13/25 and at 1:45 p.m. on 05/13/25, the Maintenance Director agreed the sprinkler locations were missing its escutcheon. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 storage rooms in the 100 Hall Conference Room in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane		**by from the practice are:** The escutcheons that was identified missing near room 201 were replaced. *See photo. Maintenance director or designee will provide training to all staff re: NFPA13 including the 18" rule. The shelf storage in the private room on 100 hall was removed immediately allowing greater than 18 inches of space between the shelf and the ceiling. **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 this practice. The escutcheon that was identified as missing outside of room 201 has been replaced. *See photo. The shelf storage in the private room on 100 hall was removed immediately allowing greater than 18 inches of space between the shelf and the ceiling. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The maintenance director or designee will inspect the storage shelf in private room on 100 hall to ensure ongoing compliance: 5x per week X1 month, then 3x per week x2 months, then 1x per week x3 months to ensure ongoing compliance. Maintenance Director or designee will do a whole house audit to ensure that all escutcheons are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the 100 Hall Conference Room. Findings include: Based on observations with the Maintenance Director at 10:33 a.m. on 05/13/25, shelf storage inside the Private room inside the 100 Hall Conference Room by Room 122 was within eighteen inches of the ceiling mounted sprinkler installed in the room. Based on interview at 10:33 a.m. on 05/13/25, the Maintenance Director agreed shelf storage was within 18 inches of the sprinkler deflector in the room. These findings were not reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		intact: 1x per week x1 month, then 2x per month x 2months, then 1x per month x3 months. *see attachments Maintenance director or designee will provide training to all staff re: 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 put into place:** Audits will be reviewed at the monthly QAPI meetings to ensure compliance. **Date of compliance: June 6, 2025**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review, observation and interview; the facility failed to ensure a full hydrostatic flush was performed for 1 of 4 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to	K 0353	**K353 SS=F Sprinkler system – Maintenance and testing** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The laundry room sprinkler head was cleaned immediately, the Maintenance Director will inspect the sprinkler heads and escutcheons throughout the facility to check for cleanliness and serviceability 1x per quarter.	07/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler: Five Year Internal Pipe Inspection" documentation dated 12/15/20 with the Maintenance Director at 12:15 p.m. on 05/12/25, the "Inspection Results" for dry pipe System #3 was listed as " System needs flushed". Based on interview at 12:15 p.m. on 05/12/25, the Maintenance Director stated no sprinkler flushing or additional internal pipe inspection documentation on or after 12/15/20 was available for review. The Maintenance Director stated a flush was not performed because the Corporate Office stated it didn't fail the inspection and it was a recommendation to flush. Based on observations with the Maintenance Director at 10:04 a.m. on 05/13/25, the sprinkler system inspection contractor had affixed an internal pipe inspection sticker to the wet and dry sprinkler systems in the 100 Hall sprinkler riser room but the sticker did not state flushing was performed and did not state the results of the 12/15/20 internal pipe inspection. Based on observations with the Maintenance Director at 11:57 a.m. on 05/13/25, the sprinkler system inspection contractor had affixed an internal pipe inspection sticker to the wet and dry sprinkler systems in the 500 Hall sprinkler riser room but the sticker did not state		The fire system maintenance vendor was contacted and a flush of the dry system will be completed July 2, 2025. SafeCare will complete quarterly inspections ongoing and will provide appropriate documentation of the inspections. **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 this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The laundry room sprinkler head was cleaned immediately , the Maintenance Director will inspect the sprinkler heads and escutcheons throughout the facility to check for cleanliness and serviceability 1x per quarter. The fire system maintenance vendor was contacted and a flush of the dry system will be completed July 2, 2025. SafeCare will complete quarterly inspections ongoing and will provide appropriate documentation of the inspections. **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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	flushing was performed and did not state the results of the 12/15/20 internal pipe inspection. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview, the facility failed to ensure 1 of 4 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler: Five Year Internal Pipe Inspection" documentation dated 12/15/20 with the Maintenance Director at 12:15 p.m. on 05/12/25, three of the facility's four sprinkler systems had a documented internal pipe inspection within the most recent five year period. Internal pipe inspection documentation for the facility's fourth sprinkler system was not available for review. Based on interview at 12:15 p.m. on 05/12/25, the Maintenance Director stated no		reviewed at the monthly QAPI meetings to ensure compliance. **Date of compliance: July 2, 2025**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	additional sprinkler system internal pipe inspection documentation on or after 12/15/20 for the facility's fourth sprinkler system was available for review. Based on observations with the Maintenance Director at 10:04 a.m. on 05/13/25, the sprinkler system inspection contractor had affixed an internal pipe inspection sticker to the wet and dry sprinkler systems in the 100 Hall sprinkler riser room but the sticker did not state the results of the 12/15/20 internal pipe inspection. Based on observations with the Maintenance Director at 11:57 a.m. on 05/13/25, the sprinkler system inspection contractor had affixed an internal pipe inspection sticker to the wet and dry sprinkler systems in the 500 Hall sprinkler riser room but the sticker did not state the results of the 12/15/20 internal pipe inspection. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to provide written documentation or other evidence sprinkler system components had been inspected and tested for 1 of 4 quarters. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, Section 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintenance of the system components and shall be made available to the authority having jurisdiction upon request. NFPA, 25 Section 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler: Report of Inspection-Equipment" documentation dated 05/01/24, 08/22/24, 11/15/24 and 04/29/25 with the Maintenance Director at 2:45 p.m. on 05/12/25, no first quarter (January, February, March) 2025 sprinkler inspection documentation was available for review. It was 165 days in between documented quarterly sprinkler system inspection and testing during the fourth quarter 2024 and the second quarter 2025. Based on interview at 2:45 p.m. on 05/12/25, the Maintenance Director stated the sprinkler contractor came 02/24/25 to perform the inspection but did sprinkler repairs instead and agreed no first quarter (January, February, March) 2025 sprinkler inspection documentation was available for review at the time of the survey. Based on observations with the Maintenance Director at 10:04 a.m. on 05/13/25, the sprinkler system inspection contractor had affixed hanging tags to the wet and dry sprinkler systems in the 100 Hall sprinkler riser room which did not document a first quarter 2025 sprinkler system inspection. Based on observations with the Maintenance Director at 11:57 a.m. on 05/13/25, the sprinkler system inspection contractor had affixed hanging tags to the wet and dry sprinkler systems in the 500 Hall sprinkler riser room which also did not document a first quarter 2025			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sprinkler system inspection. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of over 2 sprinkler heads in the Laundry room covered with lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect two staff in the Laundry Room. Findings include: Based on observations with the Maintenance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director at 1:30 p.m. on 05/13/25, the ceiling mounted sprinkler located in the dryer area of the Laundry Room was loaded with lint. Based on interview at 1:30 p.m. on 05/13/25, the Maintenance Director stated Laundry Room staff regularly clean sprinkler heads in the room but agreed the aforementioned sprinkler location was loaded with lint. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Based on observation and interview, the facility failed to ensure corridor walls in 1 of 8 smoke compartments in the facility were constructed to resist the transfer of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of ice machine/water machine in the main entrance lobby. Findings include: Based on observations with the Maintenance Director at 12:53 p.m. on 05/13/25, two separate holes were noted in the corridor wall behind the ice machine/water machine in the main entrance lobby which would not resist the transfer of smoke. Based on interview at 12:53 p.m. on 05/13/25, the Maintenance Director stated a water fountain had been in place at that location but it was replaced with the ice machine/water machine and agreed the holes in the wall would not resist the passage of smoke.	K 0362	**K362 SS=E Corridors – Construction of walls** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The holes behind the ice machine in the main lobby were fixed May 15, 2025.. *please see photos. **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 this practice. The holes behind the ice 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 by:** Maintenance Director will inspect	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		walls for damage daily during maintenance rounds. In addition, items that are identified will be corrected immediately by the 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 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director at 12:38 p.m. on 05/13/25, the corridor door to resident sleeping Room 321 failed to latch into the door frame when tested to close multiple times. The latching mechanism on the door failed to protrude into the latching plate on the door frame. Based on interview at 12:38 p.m. on 05/13/25, the Maintenance Director agreed the corridor door to resident sleeping Room 321 failed to latch into the door frame when tested to close multiple times. Based on observations with the	K 0363	**K363 SS=E Corridor - doors** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The defective latch on door of room 321 was replaced immediately. The jar that was used to keep the Business office door open was removed immediately. **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 this practice. The defective latch on door of room 321 was replaced immediately. The jar that was used to keep the Business office door open was removed	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Director at 12:56 p.m. on 05/13/25, the corridor door to the Business Office behind the reception desk at the main entrance lobby was propped in the fully open position with a jar placed on the floor up against the door. Based on interview at 12:56 p.m. on 05/13/25, the Maintenance Director agreed the corridor door to the Business Office was propped in the fully open position with a jar placed on the floor up against the door. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		immediately. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The defective latch on door of room 321 was replaced immediately. The jar that was used to keep the Business office door open was removed immediately. The maintenance director or designee will inspect all facility doors to ensure proper latching; 5x per week X1 month, then 3x per week x2 months, then 1x per week x3 months to ensure ongoing compliance. *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 put into place:** Audits will be reviewed at the monthly QAPI meetings to ensure compliance. **Date of compliance: June 6, 2025**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric 1. Based on record review, observation and interview; the facility failed to ensure that the emergency generator has a reliable source of fuel in accordance with the requirements of NFPA 101, 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, Section 5.1. LSC Section 9.1.3.1 states emergency generators shall be	K 0511	**K511 SS= E Utilities – Gas and Electric** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** An updated letter with the correct	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. Section A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director at 2:45 p.m. on 05/12/25, the natural gas reliability letter from the off-site fuel supplier for the facility's natural gas fuel-fired emergency generator was not dated. As a result, the date of the recent history of the reliability of fuel supply or interruption could not be established. Based on interview at 2:45 p.m. on 05/12/25, the Maintenance Director stated additional natural gas reliability letter documentation from the off-site fuel supplier was not available for review and agreed the reliability letter was not dated. Based on observations with the Maintenance		date was obtained from NIPSCO/ gas provider re: the facility's natural gas fuel-fired emergency generator. *See attachment. The receptacles behind the lobby ice machine were equipped with a cover plate and the holes in the wall were repaired. *See photo. The electrical outlet in the conference room bathroom was replaced with a GFI outlet. *See photo. The Maintenance Director inspected the entire facility to ensure that GFIs are present as appropriate. *see attachment **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 this practice. An updated letter with the correct date was obtained from NIPSCO/ gas provider re: the facility's natural gas fuel-fired emergency generator. The receptacles behind the lobby ice machine were equipped with a cover plate and the holes in the wall were repaired. The outlet in the conference room bathroom and behind the lobby ice machine were replaced with GFI outlets. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** An updated letter with the correct date was obtained from NIPSCO/ gas provider re: the facility's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director at 11:13 a.m. on 05/13/25, the facility has one natural gas fuel-fired emergency generator located outside the building on the north side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 150 kW. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure all electrical wiring in the facility was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314 states exposed terminals and receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 20 residents, staff and visitors in the north hall. Findings include: Based on observations with the Maintenance Director at 12:53 p.m. on 05/13/25, the two receptacles installed on the corridor wall behind the ice machine/water machine near the main entrance lobby was not confined within an outlet box. In addition, the receptacles were not equipped with a cover plate. Based on interview at 12:53 p.m. on 05/13/25, the Maintenance Director agreed the receptacles were not enclosed so that live wiring terminals are not exposed to contact. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		natural gas fuel-fired emergency generator. The receptacles behind the lobby ice machine were equipped with a cover plate and the holes in the wall were repaired. The outlet in the conference room bathroom and behind the lobby ice machine were replaced with GFI outlets. Going forward all GFI outlets will be audited bi-annually by the Maintenancve Director or designee. **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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. Based on observation and interview, the facility failed to ensure 1 of over 50 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one staff while in the restroom in the Conference Room by Room 122. Findings include: Based on observations with the Maintenance Director at 10:39 a.m. on 05/13/25, the two electrical receptacles installed in the wall mounted outlet box two feet from the sink in the restroom in the Conference Room by Room 122 were not provided with ground fault circuit interrupters (GFCI). The receptacles did not trip when tested with an Ideal Industries GFCI testing device.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION 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 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review, observation and interview; the facility failed to document a complete written record of monthly generator load testing for 1 month of the most recent 12 month period in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 8.4.1 states Emergency Power Supply Systems (EPSS), including all appurtenant components shall be inspected weekly and exercised under load at least monthly. Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 99, 2012 Edition, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators:	K 0918	**K918 SS=F Electrical systems – Essential electric system** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The facility is unable to correct past deficient practice. The maintenance director or designee will perform and document the generator load bank test monthly per regulations. The generator battery will be tested monthly by the maintenance director. **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 this practice. The maintenance director or designee will perform and document the generator load bank test monthly per regulations. The generator battery will be tested monthly by the maintenance director.	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Test Generator Under Load" documentation with the Maintenance Director at 2:07 p.m. on 05/12/25, monthly load testing documentation for 04/30/25 listed the "Run time under load" as "25" minutes. Based on interview at 2:07 p.m. on 05/12/25, the Maintenance Director stated he may have keyed in the wrong run time but agreed the 04/30/25 monthly load testing documentation indicated monthly emergency generator load testing documentation for April 2025 was not documented as a minimum of 30 minutes. Based on observations with the Maintenance Director at 11:13 a.m. on 05/13/25, the facility has one natural-gas fired emergency generator located outside the building on the north side of the property. Manufacturer's nameplate documentation affixed to the generator indicated it was rated at 150 kW. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure a complete written record of monthly testing of emergency generator starting batteries was maintained for 10 months of the most recent 12 month period in accordance with NFPA 99. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. NFPA 110, Section 8.3.7.1 states the maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or		**The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The maintenance director or designee will perform the generator load bank test monthly per regulations. The generator battery will be tested monthly by the maintenance director. The ED or designee will audit the monthly results 1x per month x6 months to ensure compliance. *See attached audit **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**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	warranted. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection contractor's "Generator: Level 2 Service" documentation dated 06/28/24 and 11/21/24 with the Maintenance Director at 2:45 p.m. on 05/12/25, the results of emergency generator starting battery electrolyte testing was listed as passing. Based on interview at 2:45 p.m. on 05/12/25, the Maintenance Director stated additional emergency generator starting battery testing documentation for the most recent twelve month period was not available for review. Based on observations with the Maintenance Director at 11:13 a.m. on 05/13/25, the facility has one natural-gas fired emergency generator located outside the building on the north side of the property. Based on interview at 11:13 a.m. on 05/13/25, the Maintenance Director stated he does not mess with battery testing and only the generator contractor tests the starting battery. These findings were reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on observation and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for all Patient Care Related Electrical Equipment (PCREE). NFPA 99, Health Care Facilities Code, 2012 edition, sections 10.3 and 10.5 states the	K 0921	**K921 SS=F Electrical equipment – testing and maintenance** **The corrective actions that were accomplished for those residents to have been affected**	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents in the facility. Findings include: Based on observations with the Maintenance Director at 10:11 a.m. on 05/13/25, the resident bed in Room 103 was an electric bed. Based on interview at 10:11 a.m. on 05/13/25, the Maintenance Director stated all resident beds in the facility are electric beds, some PCREE in the facility is supplied by a contractor who may test the equipment but agreed PCREE testing documentation was not available for review. Based on observations with the Maintenance Director at 11:05 a.m. on 05/13/25, the resident bed and a nebulizer were noted in resident sleeping		**by from the practice are:** The facility is unable to correct past deficient practice. The maintenance director or designee will document all PCREE checks before equipment is put into service, and after any repair or modification per regulations. **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 this practice. The maintenance director or designee will document all PCREE checks before equipment is put into service, and after any repair or modification per regulations. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The maintenance director or designee will document all PCREE checks before equipment is put into service, and after any repair or modification per regulations. The ED or designee will audit the PCREE documentation log results 1x per month x6 months to ensure compliance. **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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Room 114, the resident bed in resident sleeping Room 123 was an electric bed and an oxygen concentrator was also noted in the room. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		meetings to ensure compliance. **Date of compliance: June 6, 2025**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag 1. Based on observation and interview, the facility failed to ensure 1 of 2 indoor oxygen storage areas was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2 states, if indoors, storage locations of positive-pressure gases shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floor, ceilings, and doors are of minimum 1-hour fire resistant rating. This deficient practice could affect over 40 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the shower room by Room 117. Findings include: Based on observations with Maintenance Director at 10:25 a.m. on 05/13/25, six liquid oxygen containers and seven 'E' type oxygen cylinders were stored in the oxygen storage and transfilling room by the shower room by Room 117. The ceiling consisted of one layer of drywall as observed next to the adjustable skirt type escutcheon for the ceiling mounted sprinkler in	K 0923	**K923 SS=F Gas equipment – Cylinder and container storage** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** The liquid oxygen tanks were removed from the therapy gym immediately and placed in the oxygen room on West Hall. A drywall vendor was contacted and scheduled to install drywall in oxygen room ceiling to 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 this practice. The liquid oxygen tanks were removed from the therapy gym immediately and placed in the oxygen room on West Hall. A drywall vendor was contacted and scheduled to install drywall in oxygen room ceiling to increase	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the room. Based on interview at 10:25 a.m. on 05/13/25, the Maintenance Director agreed the ceiling for the room consisted of one layer of drywall which did not enclose the room with a minimum 1-hour fire resistant rating. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 2 indoor oxygen storage areas. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet), but less than 85 cubic meters (3000 cubic feet) shall 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect one staff in the oxygen storage room by the Therapy Entrance near the Therapy Gym. Findings include: Based on observations with Maintenance Director at 11:34 a.m. on 05/13/25, two liquid oxygen containers and two 'E' type oxygen cylinders were stored in the oxygen storage room by the Therapy Entrance near the Therapy Gym. One of the two 'E' type oxygen cylinders in the room were not stored in a rack, chained or otherwise secured from falling in a proper cylinder stand or cart. A		fire resistance to a minimum of 1 hour. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The liquid oxygen tanks were removed from the therapy gym immediately and placed in the oxygen room on West Hall. The Maintenance Director or designee will reeducate all staff related to the proper storage of oxygen cylinders. A drywall vendor was contacted and scheduled to install drywall in oxygen room ceiling to increase fire resistance to a minimum of 1 hour. **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:** The Maintenance Director or designee will reeducate all staff related to the proper storage of oxygen cylinders. *See attachment **Date of compliance: June 6, 2025**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chain with one end secured to the wall was intended to be used to secure the cylinder from falling but the rest of the chain was on the floor. The other oxygen cylinder in the room was secured in a cylinder cart. Based on interview at 11:34 a.m. on 05/13/25, the Maintenance Director agreed one of the two oxygen cylinders in the room was not properly chained, stored, secured or supported in a proper cylinder stand or cart. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on record review, observation and interview; the facility failed to ensure 1 of 1 oxygen transfilling locations was in accordance with NFPA 99 Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) a designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction mechanically vented and was provided with a precautionary sign indicating that smoking in the immediate area is not permitted. Section 11.5.2.3.1(2) states the area is mechanically vented. Section 11.5.2.3.1(3) states the transfilling of liquid oxygen area shall be posted with a sign indicating that transfilling is occurring. This deficient practice could affect over 40 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the shower room by Room 117.	K 0927	**K927 SS=E Gas equipment – Transferring cylinders** **The corrective actions that were accomplished for those residents to have been affected by from the practice are**: A "No Smoking" sign was placed on the oxygen room door. *See photo. The ceiling mounted exhaust fan was replaced. *See photo **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 this practice. A "No Smoking" sign was placed on the oxygen room door. *See photo. The ceiling mounted exhaust fan was replaced. *See photo	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on review of the facility's smoking policy documentation with the Maintenance Director at 12:45 p.m. on 05/12/25, the facility allows resident and staff smoking in a designated outdoor location. Based on observations with Maintenance Director at 10:25 a.m. on 05/13/25, six liquid oxygen containers and seven 'E' type oxygen cylinders were stored in the oxygen storage and transfilling room by the shower room by Room 117. The ceiling consisted of one layer of drywall as observed next to the adjustable skirt type escutcheon for the ceiling mounted sprinkler in the room. Magnetic signage on the back of the door did not state smoking was not allowed and only that transfilling was occurring. No other signage other than the room location was on the door or in the area. In addition, a ceiling mounted exhaust fan was installed in the room but the fan was not operable. Based on interview at 10:25 a.m. on 05/13/25, the Maintenance Director stated transfilling occurs in the room, the magnetic signage is intended to be moved to the corridor side of the door when transfilling occurs and agreed the ceiling for the room consisted of one layer of drywall, the fan was not in operation and signage for the room did not include smoking in the immediate area is not permitted. These findings were reviewed with the Executive Director and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** The maintenance director or designee will inspect the oxygen room door for the presence of a “No Smoking” sign; 5x per week X1 month, then 3x per week x2 months, then 1x 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 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**	