PRINTED: 07/09/2024
FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD WILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
E 0000						
Bldg	conducted by the Ir accordance with 42 Survey Date: 06/11 Facility Number: 0 Provider Number: 1	1/24 00476 155446	E 0000	2024 Life Safety POC Majestic Care of Jefferson P The following plan of correct constitutes the facilities alleg of compliance such that all a deficiencies cited have been be corrected by the date or of indicated. The statements m	tion gation alleged a or will dates ade	
	AIM Number: 100290870 At this Emergency Preparedness Survey, Majestic Care of Jefferson Pointe was found not 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 90 at the time of this survey.			on the plan of correction are an admission to and does not constitute an agreement with alleged deficiencies herein. The remain in compliance with all State and Federal regulation facility has taken or will take actions set forth in the follow plan of correction. Majestic Care of Jefferson Prequest paper compliance for following Plan of Correction.	ot in the To II ns, the the ving Pointe or the	
E 0006 SS=F Bldg	403.748(a)(1)-(2), (1)-(2), 441.184(a 483.475(a)(1)-(2), (1)-(2), 485.625(a 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2 §418.113(a)(1)-(2 §460.84(a)(1)-(2), §483.73(a)(1)-(2), §484.102(a)(1)-(2)	### Appleted on 06/14/24 416.54(a)(1)-(2), 418.113(a))(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a))(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment), §416.54(a)(1)-(2),), §441.184(a)(1)-(2), §483.475(a)(1)-(2),), §485.68(a)(1)-(2),), §485.727(a)(1)-(2),				

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

§485.920(a)(1)-(2), §486.360(a)(1)-(2),

TITLE (X6) DATE

David Holbrook Executive Director 07/03/2024

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

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

PRINTED: 07/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIER TIC CARE OF JEFFERSON POINTE	5700 W	ADDRESS, CITY, STATE, ZIP COD /ILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION §491.12(a)(1)-(2), §494.62(a)(1)-(2)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION	
	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed,				
	and updated at least annually. The plan must do the following:				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 06/11/2024					
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	facility-based and assessment, utiliz approach, includin (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan m (1) Be based on a facility-based and assessment, utiliz approach, includin (2) Include strategemergency events assessment. Based on record refailed to maintain a Plan (EPP) that was documented, facilit risk assessment, utiliz including missing restrategies for addresidentified by the risk with 42 CFR 483.7 This deficient practice. Based on records refailed by the risk assessment, utilized to maintain a documented addressed on records refailed to the risk assessment, utilized to the risk assessment and addressed on records refailed to the risk assessment, utilized by the risk assessment and addressed on records refailed to maintain a documented facility and a documented facility and a documented facility and a documented facility approaches the risk assessment and a documented facility approaches the risk assessment and a documented facility approaches the risk assessment.	gies for addressing is identified by the risk view and interview, the facility in Emergency Preparedness is (1) based on and includes a y-based and community-based lizing an all-hazards approach, esidents and (2) included issing emergency events is assessment in accordance is assessment in accordance (3(a) (1) and 42 CFR 483.73(a) (2). iice could affect all occupants.	E 0006	Emergency Preparedness E006 SS=F Facility Risk Assessment The corrective actions that were accomplished for those residents to have been affect by from the practice are: A facility Risk Assessment was completed by the ED and Maintenance Director 6/24/24 *see the attachment How other residents of the facility were identified to potentially be affected by the practice are: All residents hav the potential to be affected by practice. A facility Risk Assessment was completed by	e e this		

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all-hazards approach. Based on an interview at

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the ED and Maintenance Director

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DEPARTMENT OF HEALTH AND HUN	FORM APPROVED				
CENTERS FOR MEDICARE & MEDIC	OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
	155446	B. WI	NG	06/11/2024	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
			5700 WILKIE DR		
MAJESTIC CARE OF JEFFERSON POINTE			FORT WAYNE, IN 46804		

MAJESTIC CARE OF JEFFERSON POINTE			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 0037 SS=F	the time of record review, the Maintenance Director and the Administrator stated a risk assessment utilizing an all-hazards approach could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1),	TAG	6/24/24. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: The ED and Maintenance Director will review and update the Facility Risk Assessment in Q1 of each calendar year. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: The Risk Assessment will be reviewed at the monthly QAPI meetings to ensure compliance. Date of compliance: 6/28/24	DATE		
Bldg	483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d) (1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	A. B	A. BUILDING		COMPL	x3) date survey COMPLETED 06/11/2024	
	ROVIDER OR SUPPLIER			5700 W	NDDRESS, CITY, STATE, ZIP COD ILKIE DR VAYNE, IN 46804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	existing staff, indivunder arrangemer consistent with the (ii) Provide emerg at least every 2 ye (iii) Maintain docur preparedness train (iv) Demonstrate semergency proced (v) If the emergen and procedures at [facility] must concupdated policies at The hospice must (i) Initial training ir policies and proceexisting hospice existing hospice and the existing hospical emproved including hospical emphasis and others. (v) Periodically reparedness (including hospical emphasis and others. (v) Maintain docur preparedness train (vi) If the emerger and procedures an	eir expected roles. ency preparedness training ears. mentation of all emergency ning. staff knowledge of dures. cy preparedness policies re significantly updated, the duct training on the end procedures. §418.113(d):] (1) Training. do all of the following: n emergency preparedness edures to all new and employees, and individuals a under arrangement, eir expected roles. taff knowledge of dures. gency preparedness training ears. view and rehearse its redness plan with hospice ling nonemployee staff), asis placed on carrying out ecessary to protect patients mentation of all emergency ning. ncy preparedness policies re significantly updated, the duct training on the						

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	A. B	A. BUILDING CC		COMP	O DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIER		•	5700 W	DDRESS, CITY, STATE, ZIP COD ILKIE DR VAYNE, IN 46804	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
IAU	*[For PRTFs at §4 program. The PR following: (i) Initial training in policies and proceexisting staff, indivunder arrangement consistent with the (ii) After initial training preparedness train (iii) Demonstrate is emergency proceed (iv) Maintain docu preparedness train (v) If the emergent and procedures and procedures and procedures and procedures and procedures and proceed it in it is a policies and proceed it is a proceed it is a policies and proceed it is a policies and proceed it is a proceed it is a policies and proceed it is a proceed it is a policies and proceed it is a proceed it is a proceed it is a policies and proceed it is a proceed it i	eir expected roles. ning, provide emergency ning every 2 years. staff knowledge of dures. mentation of all emergency ning. cy preparedness policies re significantly updated, the act training on the updated dures. 60.84(d):] (1) The PACE do all of the following: a emergency preparedness dures to all new and viduals providing on-site angement, contractors, rolunteers, consistent with es. ency preparedness training ears. staff knowledge of dures, including informing at to do, where to go, and an case of an emergency. mentation of all training. acy preparedness policies re significantly updated, the act training on the updated		IAU			DATE	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446		UILDING	NSTRUCTION	(X3) DATE COMPI 06/11	
	PROVIDER OR SUPPLIEI		•	5700 W	DDRESS, CITY, STATE, ZIP COD ILKIE DR VAYNE, IN 46804	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	of the following: (i) Initial training in policies and proce existing staff, indirunder arrangement consistent with the fill provide emergat least annually. (iii) Maintain docupreparedness trais (iv) Demonstrate emergency proce *[For CORFs at § CORF must do al (i) Provide initial the preparedness pole new and existing services under an consistent with the (ii) Provide emergat least every 2 yes (iii) Maintain docus (iv) Demonstrate emergency proce must be oriented responsibilities reemergency plan workday. The trais instruction in the I systems and sign equipment. (v) If the emergand procedures a CORF must conditions and procedures a CORF must conditions are specifically as §48.	mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. The I of the following: raining in emergency icies and procedures to all staff, individuals providing rangement, and volunteers, eir expected roles. Hency preparedness training ears. Hency preparedness policies and assigned specific garding the CORF's within 2 weeks of their first ening program must include location and use of alarm als and firefighting ency preparedness policies are significantly updated, the luct training on the updated					

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EPARTMENT OF HEALTH AND HUN	MAN SERVICES				FOR!	FORM APPROVED		
ENTERS FOR MEDICARE & MEDICA	AID SERVICES				OMB	NO. 0938-039		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPLE	TED		
	155446	B. WING			06/11/2	2024		
			STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER				ILKIE DR				
MAJESTIC CARE OF JEFFERSON POINTE			FORT WAYNE, IN 46804					
MAJESTIC CARE OF JEFFERSON FOINTE			. 51(1 /					
(XA) ID CID O (A DX)	CTATEMENT OF DEFICIENCIE		ID		I	(V.E)		

	T			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	following:			
.,	(i) Initial training in emergency preparedness			
	policies and procedures, including prompt			
	reporting and extinguishing of fires,			
	protection, and where necessary, evacuation			
	of patients, personnel, and guests, fire			
	prevention, and cooperation with firefighting			
	and disaster authorities, to all new and			
	existing staff, individuals providing services			
	under arrangement, and volunteers,			
	consistent with their expected roles.			
	(ii) Provide emergency preparedness training			
	at least every 2 years.			
	(iii) Maintain documentation of the training.			
	(iv) Demonstrate staff knowledge of			
	emergency procedures.			
	(v) If the emergency preparedness policies			
	and procedures are significantly updated, the			
	CAH must conduct training on the updated			
	policies and procedures.			
	*[For CMHCs at §485.920(d):] (1) Training.			
	The CMHC must provide initial training in			
	emergency preparedness policies and			
	procedures to all new and existing staff,			
	individuals providing services under			
	arrangement, and volunteers, consistent with			
	their expected roles, and maintain			
	documentation of the training. The CMHC			
	must demonstrate staff knowledge of			
	emergency procedures. Thereafter, the			
	CMHC must provide emergency			
	preparedness training at least every 2 years.			
	Based on record review and interview, the facility	E 0037	E037 SS=F EP Training	06/28/202
	failed to conduct annual training for the		Program	
	Emergency Preparedness Program (EPP). The LTC		The corrective actions that	
	facility must do all of the following: (i) Initial		were accomplished for those	
	training in emergency preparedness policies and		residents to have been affected	
	procedures to all new and existing staff,		by from the practice are: EP	
	individuals providing services under arrangement,		training will be provided to staff by	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024	
	PROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD VILKIE DR WAYNE, IN 46804	
(X4) ID PREFIX TAG	REGULATORY OF and volunteers, con roles; (ii) Provide e training at least ann documentation of a training; (iv) Demo emergency procedu 483.73(d) (1). This all residents in the f Findings include: Based on records re and the Maintenanc a.m., no documenta no documentation to demonstrate knowle for review. Based o records review, the Administrator state conducted within th	eview with the Administrator the Director on 06/11/24 at 10:11 tion of annual EEP training and to show staff could tedge of the EPP was available on an interview at the time of Maintenance Director and the d the EPP training was not	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIBLE OF THE APPROPRISE OF THE APPROPRIBLE OF THE APPROPRISE OF THE APPROPRICE OF THE APPROPRISE OF THE APPROPRIS	DATE DATE
E 0039 SS=F Bldg	441.184(d)(2), 483 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requil §416.54(d)(2), §4	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2),		meetings to ensure complian Date of compliance: 7/12/24	ce.

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	A. B	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING B. WING		(X3) DATE : COMPL 06/11 /	ETED
	PROVIDER OR SUPPLIER			5700 W	NDDRESS, CITY, STATE, ZIP COD ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	REGULATORY OF §483.475(d)(2), § §485.625(d)(2), § (2), §491.12(d)(2) *[For ASCs at §4' OPO, "Organization CMHCs at §485.9 §491.12, and ESF (2) Testing. The [for exercises to test to annually. The [fact following: (i) Participate in a community-based (A) When a community-based (A) When a community commun	R LSC IDENTIFYING INFORMATION 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d) , §494.62(d)(2). 16.54, CORFs at §485.68, ons" under §485.727, 120, RHCs/FQHCs at RD Facilities at §494.62]: facility] must conduct the emergency plan illity] must do all of the full-scale exercise that is			CROSS-REFERENCED TO THE APPROPRIA	TE	
	community-based functional exercise actual event. (ii) Conduct an addevery 2 years, oppor functional exercity of this section include, but is not (A) A second full-	or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale cise under paragraph (d)(2) is conducted, that may limited to the following: scale exercise that is or individual, facility-based					
	functional exercis (B) A mock disast (C) A tabletop exeled by a facilitator discussion using a	e; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a					

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

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	ľ	UILDING	NSTRUCTION	(X3) DATE COMPI 06/11	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION DATE	
140	messages, or pre to challenge an er (iii) Analyze the [fi maintain documer exercises, and en the [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annut the following: (i) Participate in a community based (A) When a commaccessible, conduct based functional (B) If the hospice man-made emerg of the emergency exempt from engascale community-facility-based functional exercise of this section is continued, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop ex led by a facilitator discussion using a clinically-relevant set of problem states.	pared questions designed mergency plan. acility's] response to and natation of all drills, tabletop mergency events, and revise regency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or munity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual actional exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed					DATE	
	I messages, or pre	pared questions designed						

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A		A. BU	A. BUILDING B. WING			COMPLETED 06/11/2024	
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD ILKIE DR		
MAJEST	IC CARE OF JEFFE	ERSON POINTE			VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a commaccessible, conducted facility-based functional exercise emergency exempt from engatull-scale community functional exercise emergency event. (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop extenditation of the emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency's emergency's emergency's emergency's emergency's emergency plan.	spices that provide inpatient hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise abased; or annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required aity based or facility-based to following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based a; or ter drill; or ercise or workshop led by a sudes a group discussion clinically-relevant rio, and a set of problem end messages, or prepared and to challenge an ospice's response to and intation of all drills, tabletop pregency events and revise argency plan, as needed.					
	*[For PRFTs at §4 §482.15(d), CAHs	41.184(d), Hospitals at at §485.625(d):]					

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

Event ID:

T9OS21

Facility ID: 000476

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING			COMPLETED	
		155446	B. W	ING		06/11/	/2024	
NAME OF F	PROVIDER OR SUPPLIEF)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
					ILKIE DR			
MAJEST	IC CARE OF JEFFI	ERSON POINTE		FORT WAYNE, IN 46804				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE	
		PRTF, Hospital, CAH] must sto test the emergency						
		ar. The [PRTF, Hospital,						
	CAH] must do the							
	_	an annual full-scale exercise						
	that is community							
	-	nunity-based exercise is not						
	' '	ict an annual individual,						
		ctional exercise; or						
		Hospital, CAH] experiences						
	. ,	or man-made emergency						
	that requires activ	ration of the emergency						
	plan, the [facility]	is exempt from engaging in						
	its next required for	ull-scale community based						
	or individual, facili	ty-based functional exercise						
	following the onse	et of the emergency event.						
	(ii) Conduct a	an [additional] annual						
	exercise or and th	at may include, but is not						
	limited to the follo	_						
	' '	scale exercise that is						
	community-based							
		ctional exercise; or						
	, ,	ock disaster drill; or						
	. , ,	exercise or workshop that						
		or and includes a group						
	discussion, using							
		emergency scenario, and a						
		tements, directed						
		pared questions designed						
	to challenge an er							
	, , , -	he [facility's] response to umentation of all drills,						
		s, and emergency events cility's] emergency plan, as						
	needed.	omity of emergency plan, as						
	nocucu.							
	*[For PACE at §46							
	· ,	PACE organization must						
		s to test the emergency						
	l plan at least annu	ally The PACF	ı				I	

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Event ID:

T9OS21 Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	
		155446	B. W	ING		06/11/	/2024
N	DROLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		5700 W	ILKIE DR		
MAJEST	IC CARE OF JEFFI	ERSON POINTE		FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	organization must	-					
		an annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not lot an annual individual,					
		ctional exercise; or					
		xperiences an actual natural					
	, ,	ergency that requires					
		mergency plan, the PACE					
		gaging in its next required					
		nity based or individual,					
		tional exercise following the					
	onset of the emer	gency event.					
	(ii) Conduct a	n additional exercise every					
	2 years opposite t	he year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
		onducted that may include,					
	but is not limited t	-					
	' '	scale exercise that is					
		or individual, a facility					
	based functional e						
	(B) A mock disas						
	, ,	ercise or workshop that is					
		and includes a group					
	discussion, using						
	set of problem sta	emergency scenario, and a					
		pared questions designed					
	to challenge an er						
	_	PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
		gency plan, as needed.					
		yy p.a, a.csodod.					
	*[For LTC Facilitie	es at §483.73(d):]					
	(2) The [LTC facili	ty] must conduct exercises					
	to test the emerge	ency plan at least twice per					
	_	announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	he following:					

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Event ID:

T9OS21 Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	.ETED
		155446	B. W	NG		06/11/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	·	
NAME OF P	PROVIDER OR SUPPLIER	8			ILKIE DR		
MAJEST	IC CARE OF JEFFE	ERSON POINTE	_		VAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		in annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not ct an annual individual,					
	facility-based fund						
	•	ility] facility experiences an					
		nan-made emergency that					
		of the emergency plan, the					
	· ·	mpt from engaging its next					
	-	le community-based or					
		based functional exercise					
	_	et of the emergency event.					
	-	dditional annual exercise					
	, ,	but is not limited to the					
	following:						
	(A) A second full-	scale exercise that is					
	community-based	or an individual, facility					
	based functional e	exercise; or					
	(B) A mock disast	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		_TC facility] facility's					
	•	naintain documentation of					
		exercises, and emergency					
	The state of the s	the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	3483.475(d)]:					
	-	CF/IID must conduct					
	` '	he emergency plan at least					
		e ICF/IID must do the					
	following:						
	_	n annual full-scale exercise					
	that is community-						
	_	unity based evercise is not	1				1

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Event ID:

T9OS21 Facility ID: 000476

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

PRINTED: 07/09/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155446	B. W	ING		06/11/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ILKIE DR		
MAJEST	IC CARE OF JEFFI	ERSON POINTE			VAYNE, IN 46804		
1717 10 20 1	T						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ıct an annual individual,					
		ctional exercise; or.					
	' '	experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
	•	igaging in its next required					
		nity-based or individual,					
	onset of the emer	ctional exercise following the					
		ditional annual exercise					
	' '	but is not limited to the					
	following:	but is not innited to the					
	•	scale exercise that is					
	community-based						
	_	ctional exercise; or					
	(B) A mock disast						
	` '	ercise or workshop that is					
		and includes a group					
	discussion, using	- ·					
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	(iii) Analyze the IC	CF/IID's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48						
	(d)(2) Testing. The	e HHA must conduct					
		he emergency plan at					
	1	e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	, ,	ommunity-based exercise					
		conduct an annual					
		based functional exercise					
	every 2 years; or.						
	(B) If the HH	A experiences an actual					

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Event ID:

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	IENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	ľ	UILDING	NSTRUCTION	(X3) DATE COMPI 06/11	LETED	
	F PROVIDER OR SUPPLIE STIC CARE OF JEFF		STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE	
	natural or man-matural or man-matural or man-matural or man-matural or the exempt from engatull-scale community-based functional exercise of this section is community-based facility-based functional exercise facility-relevant set of problem statemessages, or preto challenge an elevant discussion, using clinically-relevant set of problem statemes exercises, and entitle HHA's emergencises, and entitle HHA's emergencises to test to OPO must do the (i) Conduct a papor workshop at levant emergency plan.	ade emergency that requires mergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the gency event. Iditional exercise every 2 are year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is a or an individual, ctional exercise; or isaster drill; or pexercise or workshop that to and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					
		155446	B. W	ING		06/11/	2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR FORT WAYNE, IN 46804			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	OPO is exempt from required testing exports of the emergency (ii) Analyze the Office maintain document exercises, and emitte [RNHCI's and needed. *[RNCHIs at §403]	PO's response to and ntation of all tabletop nergency events, and revise OPO's] emergency plan, as					
	exercises to test the RNHCI must do the (i) Conduct a paper at least annually. It is group discussion in the rated, clinically scenario, and a see directed message designed to challed (ii) Analyze the RN maintain documer exercises, and emitted the RNHCI's emer	he emergency plan. The	E 00	139	E039 SS=F Emergency plan		06/28/2024
	failed to conduct ex plan at least twice p unannounced staff o procedures. The LT following: (i) Participate in an is community-based a. When a commun accessible, conduct facility-based funct b. If the LTC facilit or man-made emerg of the emergency pl	dercises to test the emergency over year, including drills using the emergency of facility must do the annual full-scale exercise that driven) U U	JOY	drills/testing 2x/year The corrective actions that were accomplished for those residents to have been affect by from the practice are: EP training will be provided to state the ED and Maintenance Direct 7/12/24. An evacuation drill/training will be conducted immediately following the EP training on 7/12/24. An after training assessment/summary be written to evaluate the effectiveness of the training ar	eted ff by ctor	1 00/28/2024

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Event ID:

T9OS21 Facility ID: 000476

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PRINTED: 07/09/2024

DEPARTMENT	FC	FORM APPROVED				
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	i <u></u>	COME	PLETED
		155446	B. WING		06/1	1/2024
			STRE	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R		0 WILKIE DR		
MAJEST	IC CARE OF JEFFI	ERSON POINTE	FORT WAYNE, IN 46804			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	E COPPECTION (2	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		D BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		OT TUTTE	DATE
	community-based of	or individual, facility-based		live drill.		
		l exercise for 1 year following		How other residents of t	he	
	the onset of the actu			facility were identified to		
	(ii) Conduct an add	itional exercise that may		potentially be affected by		
	1 1	imited to the following:		practice are: All residents		
	a. A second full-sca			the potential to be affected		
		or an individual, facility-based		practice. EP training will b	-	
	functional exercise.			provided to staff by the ED		
				■ *		
	b. A mock disaster drill; or		Maintenance Director 7/12/24. A evacuation drill/training will be			
	c. A tabletop exercise or workshop that is led by a			conducted immediately fo		
facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario,			the EP training on 7/12/24	-		
		n statements, directed		<u> </u>		
	_	red questions designed to		EP drills will be held 2x pe		
		-	calendar year. Local emergency personnel will be asked to assist			
	challenge an emerg			·	assisi	
		C facility's response to and		in this live drill.	_	
		ation of all drills, tabletop		The facility has taken th		
		rgency events, and revise the		following measures to er		
	-	gency plan, as needed in		that the problem has bee		
		CFR 483.73(d)(2). This		corrected and will not re	-	
	deficient practice co	ould affect all occupants.		EP training will be provide		
				by the ED and Maintenan		
	Findings include:			Director 7/12/24. An evac		
				drill/training will be conduc		
		view with the Administrator		immediately following the		
		te Director on 06/11/24 at 10:19		training on 7/12/24. The E		
		tion of a community based		will be held 2x per calenda	-	
	,	actual natural or man-made		Quality Assurance plans		
		nnual individual facility-based		monitoring practices tha		
		if a community drill is not		been implemented to ma		
		able for review. Also,		sure corrections are ach	ieved	
		n additional annual exercise of		and are permanent are:	The	
	choice within the la	st year was not available for		outcomes of the EP drills	held 2x	
	review. Based on a	n interview at the time of		per year will be reviewed	at the	
	records review, the	Maintenance Director and the		monthly QAPI meetings to	ensure	
	Administrator state	d both required exercises have		compliance.		
	not been conducted within the last 12 months.			Date of compliance: 7/12	/24	

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This finding was reviewed with the Administrator and Maintenance Director during the exit

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/11/2024		
	PROVIDER OR SUPPLIER		5700 V	ADDRESS, CITY, STATE, ZIP COD WILKIE DR WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETIC)N
K 0000						
Bldg. 01	Licensure Survey we Department of Heal 483.90(a). Survey Date: 06/11 Facility Number: 06 Provider Number: 1 AIM Number: 1002 At this Life Safety 0 Jefferson Pointe wa Requirements for Particular Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L. Care Occupancies and This one story facility mezzanine was detection in corridor corridors and batter the resident rooms. 145 and had a census survey. All areas where the access were sprinkle facility services were	200476 55446 90870 Code survey, Majestic Care of s found not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, as C) Chapter 19, Existing Health and 410 IAC 16.2. It with an upstairs mechanical remined to be of Type V (111) as fully sprinklered. The arm system with smoke res and areas open to the y operated smoke detector in The facility has a capacity of as of 90 at the time of this residents have customary ered. All areas providing re sprinklered, except a shed rage and a garage used for	K 0000	2024 Life Safety POC Majestic Care of Jeffersor The following plan of correconstitutes the facilities a of compliance such that a deficiencies cited have be be corrected by the date indicated. The statements on the plan of correction an admission to and does constitute an agreement alleged deficiencies hereing remain in compliance with State and Federal regulating facility has taken or will take actions set forth in the foliplan of correction. Majestic Care of Jeffersor request paper compliance following Plan of Corrections.	ection Illegation Illegation Ill alleged een or will or dates s made are not s not with the n. To n all cions, the like the lowing In Pointe e for the	

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Event ID:

T9OS21 Facility ID: 000476

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

PRINTED: 07/09/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		A. BUILDING 01 B. WING		COMPLETED 06/11/2024		
	PROVIDER OR SUPPLIER		5700 W	ADDRESS, CITY, STATE, ZIP CO /ILKIE DR WAYNE, IN 46804	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Quality Review con	npleted on 06/14/24				
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arr. CLINICAL NEEDS LOCKING Where special lock clinical security neused, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock safety needs of the the Clinical or Secare being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system (at an attended lock space); and both the control of the control	king arrangements for the eds of the patient are king device shall be door and provisions shall upid removal of occupants of locks; keying of all ed by staff at all times; or means available to the 2.2.6, 19.2.2.2.5.1,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155446	B. WING		06/11/2024
NAME OF I	DROWIDER OF CUIRDLIEF		STREE	ET ADDRESS, CITY, STATE, ZIP COD	1
	PROVIDER OR SUPPLIEF			WILKIE DR	
MAJEST	IC CARE OF JEFFE	ERSON POINTE	FOR	T WAYNE, IN 46804	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DLI ICERCII	DATE
	18.2.2.2.5.2, 19.2				
	DELAYED-EGRE ARRANGEMENT				
		s lelayed-egress locking			
		in accordance with			
		permitted on door			
		g low and ordinary hazard			
		igs protected throughout by			
		ervised automatic fire			
		or an approved, supervised			
	automatic sprinkle				
	18.2.2.2.4, 19.2.2	-			
	ACCESS-CONTR				
	LOCKING ARRAN	NGEMENTS			
	Access-Controlled	d Egress Door assemblies			
	installed in accord	lance with 7.2.1.6.2 shall			
	be permitted.				
	18.2.2.2.4, 19.2.2	.2.4			
	ELEVATOR LOBE	BY EXIT ACCESS			
	LOCKING ARRAN	NGEMENTS			
	Elevator lobby exi	t access door locking in			
		7.2.1.6.3 shall be permitted			
		es in buildings protected			
		approved, supervised			
		ection system and an			
	''	sed automatic sprinkler			
	system.	0.4			
	18.2.2.2.4, 19.2.2		17.0222		0 < 10 0 10 00 1
		on and interview, the facility	K 0222	K222 SS=E Dining room a	<u>nd</u> 06/28/2024
		means of egress through 2 of		Rehab egress door codes	
		readily accessible for residents		The corrective actions that	
		iagnosis requiring specialized Doors within a required means		were accomplished for thos residents to have been affect	
	I -	be equipped with a latch or			
		ne use of a tool or key from the		by from the practice are: The deficiency was corrected	lio
		therwise permitted by LSC		immediately with door codes	
		ocking arrangements shall be		placed at each door. *see	
		ance with 19.2.2.2.5.2. This		attached photograph	
	_	ould affect 40 residents in the		How other residents of the	
	main dining room.	and the second of the second o		facility were identified to	
1				,	

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/11/2024		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE			D. WI	STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR				
	JESTIC CARE OF JEFFERSON POINTE ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: Based on observation with the Maintenance Director on 06/11/24 between 11:30 a.m. and 2:00 p.m., the main exit door on rehab and the dining exit door were marked as a facility exits, were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the exit door was not posted by the access control pad. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) potentially be affected by the practice are: All residents have the potential to be affected by this practice. This deficiency was corrected immediately with door codes placed at each door. 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 audit the presence of door codes daily Mon-Fri x4 weeks, then 2x weekly x2 months, then weekly x3 months; to ensure the door codes remain intact. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: Audits will be reviewed at the monthly QAPI meetings to ensure		e this or e by: ce of ns; ain l ve d tits	(X5) COMPLETION DATE	
K 0355 SS=E Bldg. 01			K 03	55	QAPI meetings to ensure compliance. Date of compliance: 6/28/24 K355 SS=E Portable Fire Extinguishers The corrective actions that were accomplished for those)	06/28/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED OS (141/2024)		
155446		B. WING 06/11/2024						
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE				STREET ADDRESS, CITY, STATE, ZIP COD 5700 WILKIE DR FORT WAYNE, IN 46804				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION	
TAG	Fire Extinguishers, states portable fire wheeled extinguish of the following me intended for the ext supplied by the ext listed bracket approcabinet or wall rece could affect staff ar room. Findings include: Based on observati with the Maintenant p.m., a K-class por kitchen was sitting safety pin removed time of observation stated the extinguisk nocked off the ware inspect the extinguisk This finding was reconstituted.	2010 Edition. Section 6.1.3.4 extinguishers other than lers shall be installed using any leans. (1) Securely on a hanger tinguishers. (2) In the bracket inguisher manufacturer. (3) In a loved for such purpose. (4) In a loved for such purpose. (4) In a loved for such purpose. (4) In a loved for such purpose in the dining ons during a tour of the facility like Director on 06/11/24 at 1:30 table fire extinguisher in the long the Maintenance Director like mount may have been and will have to remount and light guisher. Eviewed with the Administrator birector during the exit		TAG	residents to have been affect by from the practice are: The bracket for the fire extinguish was reattached and the extinguisher was properly huithe kitchen. *see attached photograph How other residents of the facility were identified to potentially be affected by the practice are: All residents had the potential to be affected by practice. The bracket for the extinguisher was reattached the extinguisher was properly hung in the kitchen. The facility has taken the following measures to ensure that the problem has been corrected and will not recure the maintenance director or designee will audit that all fire extinguishers remain correctly hung 1x weekly x1 month, the monthly x2 months, then more x3 months. Quality Assurance plans an monitoring practices that has been implemented to make sure corrections are achieve and are permanent are: Audit will be reviewed at the month QAPI meetings to ensure compliance. Date of compliance: 6/28/24	cted ne ne ne ng in e ve y this fire and y re by: e y en 2x nthly d ave ed ditts	DATE	
K 0920 SS=E Bldg. 01	Extens	ent - Power Cords and ent - Power Cords and						

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CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155446		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 06/11/2024			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE		
	used for componer patient-care-related (PCREE) assemble assembled by quathe conditions of the patient care was non-PCREE (e.g. except in long-ter do not use PCRE meet UL 1363A of for non-PCREE ir (outside of vicinity non-patient care in other UL standard used with general cords are not use wiring of a structual temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 9 (NFPA 70), 590.3 Based on observation failed to ensure 1 of as a substitute for frequipment with a head NFPA-70/2011, 40 permitted in 400.7 not be used for (1) This deficient practices as a substitute for frequipment with a head permitted in 400.7 not be used for (1) This deficient practices in in the company of the patients in the company of the pa	ed electrical equipment bles that have been alified personnel and meet 10.2.3.6. Power strips in icinity may not be used for , personal electronics), m care resident rooms that E. Power strips for PCREE ir UL 60601-1. Power strips in the patient care rooms if meet UL 1363. In rooms, power strips meet ids. All power strips are if precautions. Extension if as a substitute for fixed irre. Extension cords used irre. Extension cords used irre. Extension of 10.2.4. irre. (D) (NFPA 70), TIA 12-5 ion and interview, the facility if I power strips were not used ixed wiring to provide power	K 092	20	K920 SS=E Power cords The corrective actions that were accomplished for those residents to have been affect by from the practice are: The unapproved power strip was removed immediately and repl with an approved medical grace power strip. *see attached photographs How other residents of the facility were identified to potentially be affected by the practice are: All residents have	ted e laced de	06/28/2024	

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12:15 p.m., a refrigerator, microwave, and coffee

pot (high power draw equipment) were plugged

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the potential to be affected by this

practice. The unapproved power

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155446		r í	A. BUILDING <u>01</u> COMPLET					
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE			STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFI TAC	G CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE HE APPROPRIATE)	(X5) COMPLETION DATE		
	dialysis storeroom. of observation, the lipower strip was supdraw equipment. This finding was re-	ower by a power strip in the Based on interview at the time Maintenance Director agreed a oplying power to high power viewed with the Administrator irector during the exit		strip was removed in and replaced with an medical grade power The facility has take following measures that the problem has corrected and will repower strips in the faction of the maintenance distributed in the faction of the maintenance in the faction of the maintenance in the maintenance in the maintenance in the faction of the maintenance in the faction of the maintenance in the faction of the faction	n approved r strip. en the s to ensure as been not recur by: rector or ne use of acility daily then 2x hen weekly x3 o unapproved ng used in the plans and es that have to make e achieved are: Audits ne monthly nsure			
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in according to Transfilling of High Oxygen Used for lany gas from one prohibited in patie to liquid oxygen containers over 50 under 11.5.2.3.1 (liquid oxygen containers under secondary under secondary under secondary under secondary of the transfer of th	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable opsi comply with conditions NFPA 99). Transfilling to ainers or to portable for psi comply with 1.5.2.3.2 (NFPA 99).						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155446	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/11/2024			
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF JEFFERSON POINTE			STREET ADDRESS, CITY, STATE, ZIP COD 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		
	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		K 0927	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		07/12/2024		

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