	T OF HEALTH AND HU R MEDICARE & MEDIC					FOI	RM APPROVED (B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 07/31/2023		
	PROVIDER OR SUPPLIE						
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 07/3 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Care of West Aller compliance with E Requirements for N Participating Provider A83.73. The facility census of 80 at the	1/23 000215 155322	E 00	000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie of any violation of regulation. The provider respectfully requests the 2567 Plan of Correction be considered the Letter of Credit Allegation and requests a Post Survey Desk Review.	ot s forth s, or This that e ble	
E 0004 SS=C Bldg	441.184(a), 482. 484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan Annually	920(a), 486.360(a),					

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

The [facility] must comply with all applicable

Federal, State and local emergency preparedness requirements. The [facility]

§441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),

§494.62(a).

TITLE (X6) DATE

Zach Krumwied **Executive Director** 08/17/2023

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155322	A. BUILDI B. WING	NG	COMPLETED 07/31/2023
	PROVIDER OR SUPPLIER		60	REET ADDRESS, CITY, STATE, ZIP COD 050 S CR 800 E 92 ORT WAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	FIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	E COMPLETION
	comprehensive er program that mee section. The emer program must incl the following elem (a) Emergency Pladevelop and main preparedness plan and updated at lea must do all of the * [For hospitals at §485.625(a):] Emergency Plan. develop and main preparedness required comprehensive er program that mee section, utilizing a * [For LTC Facilities Emergency Plan. develop and main preparedness plan and updated at lease the section of the secti	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness its the requirements of this in all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], ast every 2 years.			
	failed to review and Emergency Prepare	view and interview, the facility I update all copies of the dness Plan (EPP) at least nce with 42 CFR 483.73(a).	E 0004	ul class="BulletListStyle1 SCXW264838150 BCX8" role="list" style="margin: 0px padding: 0px; user-select: te	

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Event ID:

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	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/31/2023	
	PROVIDER OR SUPPLIE		6050	ET ADDRESS, CITY, STATE, ZIP C O S CR 800 E 92 RT WAYNE, IN 46814	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION	
	This deficient prace Findings include: Based on records r Director on 07/31/2 maintenance copy required fields for blank and was not months. Based on Administrator at 1: provided an update May 2023. Based of record review, the Director stated not were updated and r The finding was re	eview with the Maintenance 23 at 10:30 a.m., the EPP was not updated due to all the facility to fill out was left reviewed within the past 12 records review with the 45 p.m., the Administrator ad EPP with a review date of on interview at the time of Administrator and Maintenance all available copies of the EPP		-webkit-user-drag: non -webkit-tap-highlight-co transparent; overflow: cursor: text; font-family what corrective action(accomplished for those found to have been aff deficient practice; p paraid="1100367167 paraeid="{f0d54af7-5b -ac026f38b89e}{234}" copies of the EEP were and updated.	e; blor: visible; v: verdana;" (s) will be e residents fected by the d9-4f2d-ab44 > - All e reviewed	
				how other residents had potential to be affected same deficient practice identified and what con action(s) will be taken; - All Residents have the to be affected by the depractice. All copies of the reviewed and update per paraid="457812822"	I by the e will be crective see potential eficient the EEP will ted annually.	
				paraid= 457612622 paraeid="{ca7eec4c-7c a5-7c8612404bf9}{32}	cc4-485e-90	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/31/2023	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD CR 800 E 92		
MAJESTI	IC CARE OF WEST	ALLEN			VAYNE, IN 46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
					what measures will be put into place and what systemic char will be made to ensure that th deficient practice does not red	nges e	
					- The Maintenance Director and IDT were on the process of reviewing and updating the Effannually.		
					ul class="BulletListStyle1 SCXW264838150 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: tex- -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verda how the corrective action(s) w monitored to ensure the defici practice will not recur, i.e., wh quality assurance program will put into place; and	na;" rill be ent at	
					- The "EEP" QAPI audit tool we completed by the ED or Design to ensure that the EEP is review and updated annually. The "EQAPI audit tool will be completed monthly for one month, and quarterly for 3 months. If 100% compliance is not obtained an action plan will be presented.	inee ewed EP" eted	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY MPLETED 31/2023
	PROVIDER OR SUPPLIEF		6050 S	ADDRESS, CITY, STATE, ZIP C CR 800 E 92 WAYNE, IN 46814	COD	
(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 COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE APPROPRIATE	(X5) COMPLETION DATE
E 0013 SS=C Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and properties and properties policies po	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 2.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b), 5.360(b), 5.360		monthly to the QAPI of	ommittee.	

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	OF CORRECTION	IDENTIFICATION NUMBER 155322	A. BUILDING B. WING		COMPLETED 07/31/2023	
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92		
MAJEST	IC CARE OF WEST	ALLEN	FORT	WAYNE, IN 46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) communication pla section. The policiaddress managen nonmedical emergilimited to: Fire; eq failure; care-related disasters likely to safety of the partic. The policies and previewed and upd *[For ESRD Facilitiand procedures. develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) communication pla section. The policibe reviewed and uyears. These emenot limited to, fire, failures, care-related supply interruption likely to occur in the area.	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or sipants, staff, or the public. Procedures must be atted at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must ement emergency cies and procedures, based a plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 regencies include, but are equipment or power ed emergencies, water and natural disasters are facility's geographic	E 0012	n poraid="106425409"	09/22/2022	
	failed to review and emergency prepared	riew and interview, the facility update all copies of the dness plan (EPP) Policies and annually in accordance with 42	E 0013	p paraid="196435408" paraeid="{20f012fb-d002-49187-59f6ae71b00c}{187}" > what corrective action(s) will be		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2023	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD CR 800 E 92		
MAJEST	IC CARE OF WEST	ΓALLEN	FORT WAYNE, IN 46814				
(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)	TE	(X5) COMPLETION DATE
	CFR 483.73(a). Thi all occupants.	is deficient practice could affect			accomplished for those reside found to have been affected b deficient practice;		
	Director on 07/31/2 and Procedures mai updated due to all r fill out was left blan the past 12 months.	eview with the Maintenance 23 at 10:30 a.m., the EPP Policies intenance copy was not equired fields for the facility to mk and was not reviewed within Based on records review with t 1:45 p.m., the Administrator			- All copies of the EEP wer reviewed and updated.	e	
	with a review date of interview at the time. Administrator and lead not all available coperations.	d EPP Policies and Procedures of May 2023. Based on se of record review, the Maintenance Director stated pies of the EPP Policies and odated and reviewed annually.			how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;		
		viewed with the Administrator birector during the exit			- All Residents have the poten to be affected by the deficient practice. All copies of the EEF be reviewed and updated ann	will	
					what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not rec	ges	
					- The Maintenance Director ar IDT were on the process of reviewing and updating the EE annually.		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING COMPLETE			
		155322	B. W	ING		07/31	/2023
	PROVIDER OR SUPPLIER			6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 VAYNE, IN 46814		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
E 0029 SS=C Bldg	484.102(c), 485.6: 485.727(c), 485.9: 491.12(c), 494.62: Development of C §403.748(c), §416: §441.184(c), §460: §483.73(c), §483.: §485.68(c), §485.! §485.920(c), §486: §494.62(c).	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),			how the corrective action(s) we monitored to ensure the deficipractice will not recur, i.e., who quality assurance program with put into place; and - The "EEP" QAPI audit tool we completed by the ED or Design to ensure that the EEP is reviewed and updated annually. The "EQAPI audit tool will be completed by for one month, and quarterly for 3 months. If 100° compliance is not obtained an action plan will be developed. Information will be presented monthly to the QAPI committee.	ient at ill be gnee ewed EP" eted %	

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plan that complies with Federal, State and

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	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING		ONSTRUCTION (X3) DATE SURVEY COMPLETED				
I DIN		155322	B. WI			07/31/	
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	at least every 2 ye facilities]. Based on record rev failed to review and emergency prepared Communication Pla	nn at least annually in CFR 483.73(a). This deficient	E 00)29	p paraid="1870092811" paraeid="{55be43a0-03e0-4af 5-5db2a497e408}{142}" >wha corrective action(s) will be accomplished for those reside found to have been affected by deficient practice;	t nts	08/23/2023
	Director on 07/31/2 Communication Pla updated due to all refill out was left blan the past 12 months. the Administrator at provided an updated with a review date of interview at the time Administrator and Monot all available cop	eview with the Maintenance 3 at 10:30 a.m., the EPP an maintenance copy was not equired fields for the facility to ak and was not reviewed within Based on records review with tt 1:45 p.m., the Administrator dt EPP Communication Plan of May 2023. Based on e of record review, the Maintenance Director stated bies of the EPP Communication and reviewed annually.			- All copies of the EEP were reviewed and updated including the EEP communication plan. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	g	
	_	viewed with the Administrator irector during the exit			- All Residents have the poten to be affected by the deficient practice. All copies of the EEP be reviewed and updated annu	will	
					what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not recommend.	ges e	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2023	
	PROVIDER OR SUPPLIER			6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814		
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
					- The Maintenance Director a IDT were on the process of reviewing and updating the E annually.		
					how the corrective action(s) monitored to ensure the defining practice will not recur, i.e., with quality assurance program with put into place; and	cient hat	
					- The "EEP" QAPI audit tool completed by the ED or Des to ensure that the EEP is revand updated annually. The "QAPI audit tool will be compmonthly for one month, and quarterly for 3 months. If 100 compliance is not obtained a action plan will be developed information will be presented monthly to the QAPI commit	ignee riewed EEP" leted 0% in 1. This	
E 0036 SS=C Bldg	403.748(d), 416.5 441.184(d), 482.1 484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d),					

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EP Training and Testing

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155322	B. W	ING		07/31/	2023
	ROVIDER OR SUPPLIER			6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 VAYNE, IN 46814		
			1		77.1142, 114 10011		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	· ·			CROSS-REFERENCED TO THE APPROPR		ΓE	
PREFIX TAG	§403.748(d), §416 §441.184(d), §460 §483.73(d), §485. §485.68(d), §485. §494.62(d). *[For RNCHIs at §494.62(d). *[For RNCHIs at §494.62(d). *[For RNCHIs at §494.62(d). *[For RNCHIs at §486.625 485.727, CMHCs §486.360, and RH Training and testindevelop and main preparedness train that is based on the in paragraph (a) of assessment at paragraph (b) of this section, plan at paragraph training and testing reviewed and upder training and testing and testing. The Land maintain and training and testing the emergency plan of this section, risk (a)(1) of this section at paragraph (b) ocommunication plan section. The training section. The training section.	CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION 5.54(d), §418.113(d), 6.84(d), §482.15(d), 6.475(d), §484.102(d), 6.25(d), §485.727(d), 6.360(d), §491.12(d), 6.360(d)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE .	COMPLETION DATE
	*[For ICF/IIDs at §	483.475(d):] Training and					

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	OF CORRECTION	IDENTIFICATION NUMBER 155322	A. BUILDING B. WING		COMPLETED 07/31/2023
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	maintain an emergand testing prograemergency plan so this section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/I requirements for eat §483.470(i). *[For ESRD Facility Training, testing, and the dialysis facility must emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at paragraph (a)(1) of procedures at paragraph (a) (b) procedures at paragraph (a) (c) procedures at paragraph (a) (d) of this section. The orientation program updated at every 20 Based on record revision failed to review and emergency prepared Program at least and CFR 483.73(a). This all occupants. Findings include: Based on records red Director on 07/31/2 Training Program in the section of the s	ries at §494.62(d):] and orientation. The st develop and maintain an redness training, testing ation program that is based plan set forth in paragraph risk assessment at if this section, policies and agraph (b) of this section, cation plan at paragraph (c) the training, testing and m must be evaluated and	E 0036	·p paraid="1985038775" paraeid="{1fc6d9ba-d92c-475e-30632d1d98a1}{231}" > whate corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; - All copies of the EEP well reviewed and updated including the second	ents by the

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	OF CORRECTION	IDENTIFICATION NUMBER 155322		JILDING	INSTRUCTION	COMPL 07/31/	ETED
NAME OF	PROVIDER OR SUPPLIEF	- !			ADDRESS, CITY, STATE, ZIP COD CR 800 E 92		
MAJES1	TIC CARE OF WEST	ALLEN	FORT WAYNE, IN 46814				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		TE	(X5) COMPLETION DATE
	fill out was left blar the past 12 months. the Administrator a provided an updated review date of May the time of record re Maintenance Direct copies of the EPP T and reviewed annual	nk and was not reviewed within Based on records review with t 1:45 p.m., the Administrator d EPP Training Program with a 2023. Based on interview at eview, the Administrator and for stated not all available Training Program were updated			the EEP training program. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All Residents have the potento be affected by the deficient practice. All copies of the EEP be reviewed and updated annually be made to ensure that the deficient practice does not recommend to the process of reviewing and updating the EE annually. how the corrective action(s) we monitored to ensure the deficient practice will not recur, i.e., who quality assurance program will put into place; and	itial P will ually. Deges e eur; Ind EP	

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AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/31/2023	
		133322	D. WI			07/31/	2023
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w Department of Head 483.90(a). Survey Date: 07/31 Facility Number: 00 Provider Number: AIM Number: 100	Recertification and State vas conducted by the Indiana of the in accordance with 42 CFR vas 200215	K 00		- The "EEP" QAPI audit tool we completed by the ED or Design to ensure that the EEP is review and updated annually. The "El QAPI audit tool will be complementally for one month, and quarterly for 3 months. If 100% compliance is not obtained an action plan will be developed. Information will be presented monthly to the QAPI committee monthly to the QAPI committee monthly to the QAPI committee of any violation of regulation. The statement of deficiencies of any violation of regulation. The provider respectfully requests the 2567 Plan of Correction be considered the Letter of Credit Allegation and requests a Possurvey Desk Review.	ill be nee ewed EP" ted This e. of t s forth s, or This that e ble	DATE
	Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Prote Life Safety Code (I	and not in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/31/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
K 0211 SS=E Bldg. 01	Type V (111) constisprinklered. The fawith smoke detection to the corridor and heresident rooms 310-rooms have battery. The facility has a case of 80 at the time of the access were sprinkled facility services were exception of a detact maintenance supplied. Quality Review consumplied to the access were sprinkled facility services were exception of a detact maintenance supplied. Quality Review consumplied to the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a detact maintenance supplied. When the access were sprinkled facility services were exception of a det	residents have customary ered. All areas providing re sprinklered which the shed garage used to store es and equipment. Inpleted on 08/03/23 General General ays, corridors, exit cations, and accesses are in Chapter 7, and the means uously maintained free of full use in case of is modified by 18/19.2.2	K 0211	ul class="BulletListStyle1 SCXW191942288 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdan what corrective action(s) will be accomplished for those resider	a;" e		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/23/2023 FORM APPROVED OMB NO. 0938-039

LENIERSFU	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED 07/31/2023	
		155322	B. WING			
MAJES (X4) ID	PROVIDER OR SUPPLIEI		6050 S FORT	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814 PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
	Director on 07/31/2 exit corridor contai was stored in the hatime of observation lost and found cart The finding was rev	ration with the Maintenance 23 at 12:31 p.m., the service hall ned a lost and found cart that all. Based on interview at the the Maintenance stated the was kept in the service hall. viewed with the Administrator birector during the exit		found to have been affected by deficient practice; The lost and found cart on the service hall was moved to ensithat the means of egress was of all obstructions or impedimental to the service of all obstructions or impedimental to the service of all obstructions or impedimental to the service of the serv	e ure free	
	3.1-19(b)			how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;		
				p paraid="1108637328" paraeid="{ca7eec4c-7cc4-4856 a5-7c8612404bf9}{230}" >	e-90	
				-All Residents that reside on one near the service hall have the potential to be affected by this deficient practice. All 4 means egress were ensured to be free all obstructions or	of	
				what measures will be put into place and what systemic chan will be made to ensure that the	ges	

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deficient practice does not recur;

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155322	B. WING 07/31/2023			2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
					ul class="BulletListStyle1 SCXW191942288 BCX8" role="list" style="margin: 0px; padding: 0px; user-select: text -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdar All staff were educated on the requirement of ensuring that a means of egress must remain of obstructions and impediment how the corrective action(s) w monitored to ensure the deficie practice will not recur, i.e., wha quality assurance program will put into place; and The "Means of Egress" QAPI at tool will be completed by the E or Designee to ensure that all egresses remain free of obstruction and impediment. T "Means of Egress" QAPI audit will be completed weekly for o month, and monthly for 3 mon If 100% compliance is not obtained an action plan will be developed. This information w presented monthly to the QAP committee.	na;" Ill free nts. ill be ent at I be audit ED The tool ne ths.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	COMI	E SURVEY PLETED 1/2023			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
K 0222 SS=F Bldg. 01	be equipped with requires the use of egress side unless special locking are CLINICAL NEEDS LOCKING Where special locking dinical security neutrons are detection system at an attended locks or keys carried the Clinical security neutrons are being met. In selectrical locks that release upon loss building is protected detection system at an attended locks pace); and both the clinical or security and control of the control locks or keys carried the control locks or keys carried the such reliable staff at all times. 18.2.2.2.5.1, 18.2. 19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT: Where special locks after the Clinical or Security needs of the control locks that release upon loss building is protected automatic sprinkles space is protected detection system at an attended lockspace); and both the control locks that the control locks that release upon loss building is protected detection system at an attended lockspace); and both the control locks that the control locks that release upon loss building is protected detection system at an attended lockspace); and both the control locks that the control	king arrangements for the eds of the patient are eking device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			
		155322	B. WING 07/31/2023			
NAME OF F	PROVIDER OR SUPPLIER	<u>. </u>		ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
MAJEST	IC CARE OF WEST	ΓALLEN		S CR 800 E 92 WAYNE, IN 46814		
(X4) ID	Г	STATEMENT OF DEFICIENCIE	ID	<u>, </u>	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	ì ·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	18.2.2.2.5.2, 19.2					
	DELAYED-EGRE					
	ARRANGEMENT					
	Approved, listed d	lelayed-egress locking				
	systems installed	in accordance with				
	7.2.1.6.1 shall be	permitted on door				
	assemblies servin	g low and ordinary hazard				
	contents in buildin	igs protected throughout by				
		ervised automatic fire				
		or an approved, supervised				
	automatic sprinkler system.					
	18.2.2.2.4, 19.2.2.2.4					
	ACCESS-CONTROLLED EGRESS					
	LOCKING ARRAN					
		d Egress Door assemblies				
		lance with 7.2.1.6.2 shall				
	be permitted.	0.4				
	18.2.2.2.4, 19.2.2					
		BY EXIT ACCESS				
	LOCKING ARRAN	t access door locking in				
	I	7.2.1.6.3 shall be permitted				
		es in buildings protected				
		approved, supervised				
		ection system and an				
		sed automatic sprinkler				
	system.					
	18.2.2.2.4, 19.2.2	.2.4				
		on and interview, the facility	K 0222	ul="" role="list"	08/23/2023	
		means of egress through 2 of		what corrective action(s) will I		
	5 exit doors and 1 o	of 1 exit gates were readily		accomplished for those reside		
		ents without a clinical		found to have been affected b		
		specialized security measures.		deficient practice;		
	_	nired means of egress shall not		All exit doors and exit gates I	nad	
		latch or lock that requires the		the keypad exit code posted i	n	
	1	from the egress side unless		sight by the keypad.		
	otherwise permitted by LSC 19.2.2.2.4.			p="" paraid="51601886"		
	I	gements shall be permitted in		paraeid="{99de7438-0a2e-43		
		.2.2.2.5.2. This deficient		57-3425838163f0}{134}"> ho	W	
	practice could affect	et over 55 residents.		other residents having the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2023		
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION
TAG	Findings include: Based on observation Director on 07/31/2 p.m., the 100-hall of the exit gate outsid were magnetically entering a four-digpad. The code to opposted in sight by knot have a code postume of observation agreed the codes to gate were not posted. The finding was re-	on with the Maintenance 23 between 11:30 a.m. and 1:00 exit door, 200-hall exit door, and e of 300-hall are facility exits, locked, and could be opened by it code on the access control ben the two exit doors were not expad, and the exit gate did sted. Based on interview at the in, the Maintenance Director i open the exit doors and exit and by the access control pads. Exit do by the access control pads. Exit do by the access control pads. Exit do by the exit doors and exit and by the access control pads.		TAG	potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents have the potential to affected by this deficient practice. All exit doors and exit gates whave the keypad code posted sight by the keypad. ul="" role="list" what measures will be put into place and what systemic charwill be made to ensure that the deficient practice does not recombined and will be ducated on the requirement to have the keypad. All staff will be educated on the requirement to have the keypad. How the corrective action(s) will be monitored to ensure the deficient practice who the recur, i.e., what quality assurance program will be purplace; and p="" paraid="425460149" paraeid="{99de7438-0a2e-4357-3425838163f0}{220}"> The "Means of Egress" QAPI audit will be completed by the ED on Designee to ensure that all residents receive activities da The "Means of Egress" QAPI tool will be completed weekly one month, and monthly for 3 months. If 100% compliance in obtained an action plan will be developed. This information we presented monthly to the QAF committee.	b be tice. vill in onges e cur; the ad vill t into 25-86 e t tool or audit for s not e vill be	DATE

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322		(X2) MUL A. BUII B. WIN	DING	nstruction 01	(X3) DATE COMPI 07/31	LETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lightin Emergency Lightin Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour ed automatically in					
	18.2.9.1, 19.2.9.1 #1.) Based on observation and interview, the facility failed to ensure 3 of 3 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect 6 staff and residents using the shower rooms.		K 029	P1	ul class="BulletListStyle1 SCXW9099030 BCX8" role=' style="margin: 0px; padding: user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verda what corrective action(s) will accomplished for those reside found to have been affected to deficient practice; The emergency lights in all 3 shower rooms were repaired replaced to ensure proper fur	Opx; ana;" be ents by the	08/23/2023
	Director on 07/31/2 p.m., the battery-op the three shower roo Based on interview observations, the M the battery-operated	on with the Maintenance 3 between 11:30 a.m. and 1:00 erated emergency lights inside oms did not work when tested. at the time of the aintenance Director agreed d emergency lights failed to espective test buttons were			how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; p paraid="162191364" paraeid="{bfb93b66-c6b4-40484}	e e	
	#2.) Based on recor interview, the facili battery backup light			2-35cd0d3e5d75}{67}" >	501		

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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 COMPLETED 01 B. WING 07/31/2023 155322 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6050 S CR 800 E 92 MAJESTIC CARE OF WEST ALLEN FORT WAYNE, IN 46814 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Section 7.9.3.1.1 requires functional testing shall All residents have the potential to be conducted monthly, with a minimum of 3 weeks be affected by this deficient and a maximum of 5 weeks between tests, for not practice. The maintenance director less than 30 seconds. Functional testing shall be was educated on the requirement conducted annually for a minimum of 1 1/2 hours to test all emergency shower room if the emergency lighting system is battery lights for no less 30 seconds powered. Written records of visual inspections monthly and for annually. and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 6 staff and residents using the shower rooms. what measures will be put into place and what systemic changes Findings include: will be made to ensure that the deficient practice does not recur; Based on observation with the Maintenance Director on 07/31/23 between 11:30 a.m. and 1:00 p.m., there were three battery-operated emergency light inside the three shower rooms. Based on records review at 1:40 p.m., testing documentation ul class="BulletListStyle1 for the battery powered emergency lights were not SCXW9099030 BCX8" role="list" available for review. Based on an interview at the style="margin: 0px; padding: 0px; time of record review and observation, the user-select: text: Maintenance Director confirmed there were -webkit-user-drag: none; battery powered lights in the shower rooms and -webkit-tap-highlight-color: stated the lights were not tested in the last year. transparent; overflow: visible; cursor: text; font-family: verdana;" The findings were reviewed with the All emergency shower room lights Administrator and Maintenance Director during will be no less 30 seconds the exit conference. monthly and annually. 3.1-19(b) how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The "Emergency Shower Lighting"

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155322	B. WI	NG		07/31	/2023	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					CR 800 E 92			
MAJEST	IC CARE OF WES	T ALLEN		FORT \	WAYNE, IN 46814			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG		yto d	DATE	
					QAPI audit tool will be completed by the Maintenance Director of			
					Designee to ensure that all su			
					lights are functional and teste			
					requirement. The "Emergency			
					Shower Lighting" QAPI audit t			
					will be completed weekly for o			
					month, and monthly for 3 mor	iths.		
					If 100% compliance is not			
					obtained an action plan will be			
					developed. This information w			
					presented monthly to the QAF	41		
					committee.			
K 0293	NFPA 101							
SS=E	Exit Signage							
Bldg. 01	Exit Signage							
	2012 EXISTING							
		al signs are displayed in						
		7.10 with continuous						
	lighting system.	served by the emergency						
	19.2.10.1							
	(Indicate N/A in o	ne-story existina						
	,	less than 30 occupants						
	· ·	exit travel is obvious.)						
		ervation and interview, the	K 0	293	·p paraid="1938816043"		08/23/2023	
		sure 1 of 1 exit paths did not			paraeid="{6455936e-c34c-464			
	_	it signs. This deficient practice			cb-4d1a64d49ccd}{81}" >wha	t		
		dents that need to use service			corrective action(s) will be			
	hall exit from the d	ining room.			accomplished for those reside			
	Findings include:				found to have been affected be deficient practice;	y tne		
		id d NEI v						
		on with the Maintenance						
		23 at 12:35 p.m., there were a set pors in the dinning/service						
		n "EXIT" sign above the door			The smoke doors located on t	he		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6050 S CR 800 E 92 FORT WAYNE, IN 46814				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) dining/service area hall had the conflicting signs removed leav on the EXIT sign above the do Directional signs were placed	DATE Dee ving poor. at		
	conflicting sings an sign.	d removed the "do not enter"		the end of the 300 to ensure the path of egress was direction was identifiable.			
	facility failed to instance of egress in accorda 7.10.1.2.1 exits, oth that obviously and contained by readily visible from LSC 7.10.1.2.2 states	d review and interview; the tall exit signage in 1 of 4 paths nee with LSC 7.10. LSC er than main exterior exit doors clearly are identifiable as exits, an approved sign that is any direction of exit access. es horizontal components of the n exit enclosure shall be		how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;			
	where the continuat obvious. This defici residents on the 300 Findings include:	d exit or directional exit signs ion of the egress path is not ent practice could affect 20 l-hall.		All residents have the potential be affected by this deficient practice. All staff were educated on the requirement to have Exclearly marked without conflicingly.	ed KITs		
	Director on 07/31/2 300 hall the path of gate and could not s led. There was no d the direction of the interview at the time Maintenance Direct	3 at 1:00 p.m., outside of the egress led to a locked solid ee were the path of egress irectional or exit signs to show path of egress. Based on e of observation, the or acknowledged the dition and confirmed that the		what measures will be put into place and what systemic char will be made to ensure that th deficient practice does not rec	nges e		
	path of egress was r The findings were r Administrator and M the exit conference.	eviewed with the Maintenance Director during		All Exits and Egresses will har the appropriate signage and directional information.	ve		

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l f '		IDENTIFICATION NUMBER 155322	A. BUILDING B. WING	01	COMPLETED 07/31/2023
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COD 5 CR 800 E 92 WAYNE, IN 46814	
(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)	(X5) COMPLETION DATE
	3.1-19(b)			how the corrective action(s) w monitored to ensure the defici practice will not recur, i.e., who quality assurance program will put into place; and	ent at
				The "Means of Egress" QAPI tool will be completed by the Maintenance Director or Design to ensure that all such lights a functional and tested per requirement. The "Means of Egress" QAPI audit tool will be completed weekly for one morand monthly for 3 months. If 1 compliance is not obtained an action plan will be developed. information will be presented monthly to the QAPI committee.	gnee are e nth, 00%
K 0300 SS=E Bldg. 01	Section 18.3 and requirements that provided K-tags, to information, along Safety Code or NI should be included	RKS section any LSC 19.3 Protection are not addressed by the out are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567.			
	failed to maintain la smoke barrier doors requires existing lif the public if not req	on and interview, the facility atching hardware on 1 of 4 s to the 200-hall. LSC 4.6.12.3 c safety features obvious to juired by the Code, shall be r removed. This deficient	K 0300	p paraid="333726448" paraeid="{64b3b098-adbf-4094-fa9bc9f279c0}{230}" > what corrective action(s) will be accomplished for those reside found to have been affected b	ents

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		A. BUILDING B. WING	01	COMPLETED 07/31/2023	
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	compartments.	t 33 residents in two smoke		deficient practice;	
	Director on 07/31/2 barrier doors to the latching hardware b Based on interview Maintenance Direct were equipped with doors did not proper	on with the Maintenance 3 at 11:37 a.m., the set of smoke 200-hall was provided with ut failed to latch when tested. at the time of observation, the or agreed the smoke doors latching devices, but the rly latch when tested. iewed with the Administrator irector during the exit		The set of smoke barrier door the 200 were repaired and adjusted to ensure that latchir hardware was functional. how other residents having th potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	e e
	3.1-19(b)			All residents have the potential be affected by this deficient practice. All smoke barrier dowere tested to ensure that the latched correctly.	ors
				what measures will be put into place and what systemic char will be made to ensure that th deficient practice does not red	nges e
				All smoke barrier doors will be kept in good repair and function order to ensure they latch who tested or in use.	onal

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	СОМР	ESURVEY LETED //2023
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP C CR 800 E 92 WAYNE, IN 46814	COD	
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
				how the corrective act monitored to ensure the practice will not recur, quality assurance prog- put into place; and	ne deficient i.e., what	
				The "Smoke Barrier/H Area Doors" QAPI and be completed by the M Director or Designee to that all such doors are and tested per require "Smoke Barrier/Hazard Doors" QAPI audit too completed weekly for and monthly for 3 more compliance is not obtain action plan will be devinformation will be premonthly to the QAPI completed to the premonthly to the QAPI completed weekly for any compliance is not obtain the premonthly to the QAPI completed weekly for any completed weekl	dit tool will Maintenance o ensure e functional ement. The dous Area of will be one month, oths. If 100% ained an reloped. This sented	
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automatoption is used, the from other spaces	- Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 5.7.1 or 19.3.5.9. When the tic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4.				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155322	B. WING 07/31/2023			2023	
				CTD FFT A	ADDRESS STEW STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
NAA JEGT		- 411 -			CR 800 E 92		
MAJEST	IC CARE OF WEST	ALLEN		FORTV	VAYNE, IN 46814		
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	automatic-closing	and permitted to have					
	_	applied protective plates that					
		inches from the bottom of					
	the door.						
	Describe the floor	and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	,						
	Area	Automatic Sprinkler					
	Separation	-					
	·	-Fired Heater Rooms					
		er than 100 square feet)					
		nance, and Paint Shops					
	•	ooms (exceeding 64					
	gallons)	, ,					
	e. Trash Collection	n Rooms					
	(exceeding 64 gal	lons)					
	, -	orage Rooms/Spaces					
	(over 50 square fe	-					
	g. Laboratories (if	classified as Severe					
	Hazard - see K32	2)					
	Based on observation	on and interview, the facility	K 0	321	·p paraid="529738787"		08/23/2023
	failed to ensure the	corridor doors to 2 of 5			paraeid="{8e4ef46b-9049-408	0-b57	
	hazardous areas cor	ntaining fuel fired equipment			2-73294b632977}{9}" >what		
	was provided with a	a self-closing device which			corrective action(s) will be		
	would cause the do	or to automatically close and			accomplished for those reside	nts	
	latch into the door f	rame. This deficient 40			found to have been affected by	y the	
	residents in two sm	oke compartments.			deficient practice;		
	Findings include:						
	Based on observation	ons during a tour of the facility					
		ce Director on 07/31/23 at			The doors to the mechanical re	oom	
		05 p.m., the furnace room in the			on 200 and the dining room we	ere	
		e mechanical room on the			repaired to ensure they latche	d.	
		tain fuel fired equipment were					
	equipped with self-	closing devices, but the doors					
		e frame when tested. Based on					
	interview at the tim	e of observation, the			how other residents having the	e	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 07/31/2023			
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	hazardous areas cor and the doors did no frame when tested.	or agreed the rooms were nataining fuel fired equipment of automatically latch into the		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	
		viewed with the Administrator irector during the exit		All residents have the potential be affected by this deficient practice. The maintenance dirwas educated on the requirement that all self-closing doors to hazardous areas must latch witested.	ector nent
				what measures will be put into place and what systemic chan will be made to ensure that the deficient practice does not rec	ges e
				All doors with hazardous mate were inspected to ensure that self-closing door was in place that the door latched to the frawhen tested.	a and
				how the corrective action(s) w monitored to ensure the defici- practice will not recur, i.e., who quality assurance program will put into place; and	ent at

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	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER 155322	A. BUILDING B. WING	01	COMPLETED 07/31/2023
	ROVIDER OR SUPPLIER C CARE OF WEST		6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 VAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System Maintenance A fire alarm syster in accordance with complying with the National Electric C National Fire Alarm Records of system and testing are rea 9.6.1.3, 9.6.1.5, NI Based on observation failed to ensure 1 of stations) in the 100- 9.6.1.3 states a fire a safety shall be instal accordance with the NFPA 70, National	a - Testing and a - Testing and a is tested and maintained a an approved program a requirements of NFPA 70, code, and NFPA 72, an and Signaling Code. a acceptance, maintenance adily available.	K 0345	The "Smoke Barrier/Hazardou Area Doors" QAPI audit tool who completed by the Maintenan Director or Designee to ensure that all such doors are function and tested per requirement. The "Smoke Barrier/Hazardous Area Doors" QAPI audit tool will be completed weekly for one morand monthly for 3 months. If the compliance is not obtained an action plan will be developed, information will be presented monthly to the QAPI committee monthly to the QAPI committee to decide the compliance action (s) will be accomplished for those reside found to have been affected by deficient practice;	s ill noce e hal ne ea hal
	2010 edition 17.14.5	5 states manual fire alarm boxes that they are conspicuous,		The lift blocking the manual fingler alarm box was moved to ensure that the alarm was unobstructed.	re

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 01 COMPLETE B. WING 07/31/20			LETED		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD CR 800 E 92		
MAJESTI	IC CARE OF WEST	ALLEN			VAYNE, IN 46814		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	· ·	ccessible. This deficient			and accessible. how other		
	practice could affec	t 25 residents in the 100 hall.			residents having the potential		
	Findings include:				be affected by the same deficient		
	rindings include.				practice will be identified and what		
	Rased on observation	on with the Maintenance			corrective action(s) will be taken; All residents have the		
		3 at 12:01 p.m., the pull station			potential to be affected by this	2	
		had a Hoyer lift parked in front			deficient practice. All staff	•	
		Based on interview at the			were educated on the require	ment	
	*	n, the Maintenance Director			that all manual fire alarm boxe		
		blocking the pull station and			unobstructed and accessible.		
	removed the lift.				what measures will be put in	to	
					place and what systemic char		
	The finding was rev	riewed with the Administrator			will be made to ensure that th	-	
	and Maintenance D	irector during the exit			deficient practice does not		
	conference.				recur; All manual pull alarms	will	
					be installed and maintained ir	na	
	3.1-19(b)				that keeps them unobstructed		
					accessible. how the corrective	/e	
					action(s) will be monitored to		
					ensure the deficient practice v	vill	
					not recur, i.e., what quality		
					assurance program will be pu		
					place; and The "Fire Detection		
					and Alarm system" QAPI aud	IL	
					tool will be completed by the Maintenance Director or Desi	anee	
					to ensure that all system	griee	
					requirements are met and		
					maintained. The "Fire Detection	on	
					and Alarm system" QAPI aud		
					tool will be completed weekly		
					one month, and monthly for 3		
					months. If 100% compliance i		
					obtained an action plan will be		
					developed. This information v		
					presented monthly to the QAF		
			1		committee.		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155322	B. W	NG		07/31/	/2023
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹					
MAJEST	IC CARE OF WEST	TALLEN		6050 S CR 800 E 92 FORT WAYNE, IN 46814			
(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	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0351	NFPA 101						
SS=E	Sprinkler System	- Installation					
Bldg. 01	Spinkler System -	Installation					
	2012 EXISTING						
	Nursing homes, a	nd hospitals where required					
	by construction type						
	throughout by an	approved automatic					
	sprinkler system ir	n accordance with NFPA					
	13, Standard for the	he Installation of Sprinkler					
	Systems.						
	In Type I and II co	nstruction, alternative					
	protection measures are permitted to be substituted for sprinkler protection in specific						
	areas where state	or local regulations prohibit					
	sprinklers.						
		klers are not required in					
	clothes closets of	patient sleeping rooms					
	where the area of	the closet does not exceed					
	1	sprinkler coverage covers					
		t as required by NFPA 13,					
	Standard for Insta	llation of Sprinkler					
	Systems.						
		, 19.3.5.3, 19.3.5.4,					
		9.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 0	351	p="" paraid="1961862901"		08/23/2023
		f 6 sprinklers in the 200-hall			paraeid="{ff173100-46af-438c	-8f9f-	
		were installed in accordance			5b66fd610a12}{124}">what		
		0 Edition. Section 8.6.3.4.1			corrective action(s) will be		
		quirements of 8.6.3.4.2,			accomplished for those reside		
		.4 are met, sprinklers shall be			found to have been affected b	y the	
	_	n 6 ft (1.8 m) on center. This			deficient practice;		
	1	ould affect 20 residents in one			The Sprinkler heads in the ha	.II	
	smoke compartmen	t.			200 lounge/dining hall were		
	T. 1				repaired to ensure that they w		
	Findings include:				a minimum of 6 feet apart. ho	W	
		tal at the train			other residents having the		
		on with the Maintenance			potential to be affected by the		
		3 at 11:20 a.m., in the 200-hall			same deficient practice will be		
		there were two sprinklers 5			identified and what corrective		
	teet apart. Based on	interview at the time of the			action(s) will be taken; All		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155322	B. W	ING	07/31/2023		
NAME OF F	DOMNED OF CLIPPLIES		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIER			6050 S	CR 800 E 92		
MAJEST	IC CARE OF WEST	ALLEN		FORT V	WAYNE, IN 46814		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)	DATE	
		aintenance Director agreed less than six feet apart and			residents have the potential to		
	provide the measure	•			affected by this deficient pract		
	provide the measure	ement of five feet.			An audit was performed to entithe that all sprinkler heads were a		
	The finding was rev	viewed with the Administrator			minimum of 6 feet apart. wha		
	_	irector during the exit			measures will be put into place		
	conference.	ummg me omi			and what systemic changes w		
					be made to ensure that the		
	3.1-19(b)				deficient practice does not		
					recur; All sprinkler heads will	be	
					a minimum of 6 feet apart. he		
					the corrective action(s) will be		
					monitored to ensure the defici	ent	
					practice will not recur, i.e., wh	at	
					quality assurance program wil	l be	
					put into place; and The "Sprir	ıkler	
					/Fire Suppression System" QA		
					audit tool will be completed by		
					Maintenance Director or Desig		
					to ensure that all sprinkler hea	nds	
					are a minimum of apart. The		
					"Sprinkler/Fire Suppression		
					System" QAPI audit tool will b		
					completed weekly for one mor		
					and monthly for 3 months. If 1		
					compliance is not obtained an action plan will be developed.		
					information will be presented	11115	
					monthly to the QAPI committee	e.	
					and the same of the continued		
K 0353	NFPA 101						
SS=E	Sprinkler System	- Maintenance and Testing					
Bldg. 01		- Maintenance and Testing					
	Automatic sprinkle	er and standpipe systems					
	are inspected, tes	ted, and maintained in					
		NFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
	1	n design, maintenance,					
	inspection and tes	sting are maintained in a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>01</u>			COMPLETED	
		155322	B. WI	NG		07/31	/2023	
	PROVIDER OR SUPPLIER			6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 VAYNE, IN 46814			
(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	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		nd readily available. system last checked						
	b) Who provided system test							
	c) Water system	supply source						
	coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, #1.) Based on obser facility failed to enskitchen were not look NFPA 25, 2011 edinot show signs of lecorrosion, foreign radianage; and shall borientation (e.g., up Furthermore, at 5.2. signs of any of the Leakage (2) Corros Loss of fluid in the element (5) Loading the sprinkler manuficould affect staff and smoke compartment. Findings include: Based on observation Director on 07/31/2 two sprinkler heads green and showed seprinkler heads by the dirt and grease. Base observation, the Market in the sprinkler in the sprinkler heads by t	yation and NFPA 25 revation and interview, the sure 4 of 8 sprinklers in the aded and free of corrosion. tion, at 5.2.1.1.1 sprinklers shall eakage; shall be free of materials, paint, and physical be installed in the correct right, pendent, or sidewall). 1.1.2 any sprinkler that shows following shall be replaced: (1) ion (3) Physical Damage (4) glass bulb heat responsive g (6) Painting unless painted by facturer. This deficient practice and up to 20 residents in one t.	K 0:	353	p="" paraid="87169247" paraeid="{679fcdae-59e2-420 2-1c8d16f51fc2}{72}">what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; The 4 Sprinkler heads noted the kitchen as not being free of corrosion and not loaded were cleaned or replaced by the sprinkler system service provice The sprinkler noted as being obstructed by a decoration has the obstruction removed. In the obstruction removed identified and what corrective action(s) will be taken; All residents have the potential to affected by this deficient pract An audit was performed to en that all sprinkler heads were for corrosion, unloaded, free of for materials, and in functional or what measures will be put in place and what systemic char will be made to ensure that the	ents by the in br e der. s by be tice. sure ree breign der. to nges	08/23/2023	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155322		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/31/2023	
	ROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to ensithe 100-hall corrido accordance with 19. Section 8.5.5.1 state as to minimize obstudefined in 8.5.5.2 ar sprinklers shall be proverage of the hazar could up to 25 reside Findings include: Based on observation Director on 07/31/2 sprinkler head in the decoration hang from interview at the time Maintenance Director The findings were resident.	on with the Maintenance 3 at 11:5 a.m., the middle e 100-hall was obstructed by a m the sprinkler head. Based on e of observation, the or removed the decoration.		deficient practice does not recur; All sprinkler heads wil not loaded and free of corrosic All sprinklers will not show sig of leakage; be free of corrosic foreign materials, paint, and physical damage. how the corrective action(s) will be monitored to ensure the defici practice will not recur, i.e., wh quality assurance program wi put into place; and The "Sprin/Fire Suppression System" Quaudit tool will be completed by Maintenance Director or Desig to ensure that all sprinklers wi not show signs of leakage; she free of corrosion, foreign materials, paint, and physical damage. The "Sprinkler/Fire Suppression System" QAPI a tool will be completed weekly one month, and monthly for 3 months. If 100% compliance i obtained an action plan will be developed. This information we presented monthly to the QAF committee.	ent at II be akler API the gnee II all udit for s not e
K 0361 SS=E Bldg. 01	treatment rooms a waiting areas, nursand cooking facilit in accordance with and 19.3.6.1. 18.3.6.1, 19.3.6.1	Open to Corridor In patient sleeping rooms, Ind hazardous areas), Ise's stations, gift shops, Ites, open to the corridor are In the criteria under 18.3.6.1			
	based on observation	on and interview, the facility	K 0361	·p paraid="866645037"	08/23/2023

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	OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/31/2023	
	PROVIDER OR SUPPLIE			6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF failed to ensure 2 of corridor were provided to the corridor to	STATEMENT OF DEFICIENCIE RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION of 2 lounges open to the ide with electrically supervised etection system. LSC 19.3.6.1(7) ther than patient sleeping boms, and hazardous areas shall idor and unlimited in area, pace and corridors which the in the same smoke compartment electrically supervised etection system in accordance in Each space is protected by an interest or equired exits. This deficient et staff and up to 25 residents		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDEFICIENCY) paraeid="{e9a2a411-02ee-4cef-18559d7c0972}{240}" > who corrective action(s) will be accomplished for those resid found to have been affected deficient practice; The two lounges at the end of 200 were provided with elect supervised automatic smoke detection.	d33-9c nat ents by the	(X5) COMPLETION DATE
	Director on 07/31/2 at the end of the 20 and were not provide automatic smoke duthe time of observational were not provide automatic smoke duthe time of the time of the time of the time of observation and were not provide automatic smoke duther the finding was resulted.	ons with the Maintenance 23 at 11:39 a.m., the two lounges 10-hall were open to the corridor ded with electrically supervised etection. Based on interview at tition, the Maintenance Director nges were open to the corridor ded with electrically supervised etection. viewed with the Administrator Director during the exit			how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potent be affected by this deficient practice. An audit was perfort to ensure that all areas requiring electrically supervisautomatic smoke detection	e e e al to med	

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what measures will be put into place and what systemic changes

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>01</u>	COMPLETED
		155322	B. WING		07/31/2023
		100022			0170172020
NAME OF P	PROVIDER OR SUPPLIER	8		EET ADDRESS, CITY, STATE, ZIP COD	
TVIVIL OF T	KO VIDEK OK SOIT EIEF		605	0 S CR 800 E 92	
MAJEST	IC CARE OF WEST	Γ ALLEN	FOF	RT WAYNE, IN 46814	
OVA ID	CID D (1 DV	OT A TEN ON TO SE DEFICIENCIE			l are
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				will be made to ensure that t	he
				deficient practice does not re	ecur;
				All areas requiring electricall	,
				supervised automatic smoke	
				detection will and have elect	
				supervised automatic smoke	
				detection present.	
				·how the corrective action(s) will
					s) wiii
				be monitored to ensure the	
				deficient practice will not rec	ur,
				i.e., what quality assurance	
				program will be put into place	e;
				and	
				The "Sprinkler /Fire Surre-	oion
				The "Sprinkler /Fire Suppres	
				System" QAPI audit tool will	
				completed by the Maintenan	
				Director or Designee to ensu	
				that all areas requiring electr	ically
				supervised automatic smoke	
				detection will and have elect	
				supervised automatic smoke	
				detection present. The	
				"Sprinkler/Fire Suppression	
				1	ha
				System" QAPI audit tool will	
				completed weekly for one me	
				and monthly for 3 months. If	100%
				compliance is not obtained a	n

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action plan will be developed. This

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 155322 B. WING 07/31/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6050 S CR 800 E 92

MAJEST	TIC CARE OF WEST ALLEN	FORT	FORT WAYNE, IN 46814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 2 receptacles within 6 feet from a sink 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-interrupter 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, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink, (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment,	K 0511	information will be presented monthly to the QAPI committee. p="" paraid="2019875007" paraeid="{fb2d89a6-2ef6-4b99-9e8 2-6ca3770c6162}{152}">what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The electrical receptacle within less than 6 feet of a sink in the main dining room that was not GFCI protected was removed or replaced with a GFCI protected receptacle. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this deficient practice. An audit was performed to ensure that all receptacles that require GFCI protection have GFCI protection. What measures will be put into place and what systemic changes will be made to ensure	08/23/2023	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPL	ETED
		155322	B. WING			07/31/	2023
			S	TREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L.			CR 800 E 92		
MAJESTI	IC CARE OF WEST	ALLEN			VAYNE, IN 46814		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
		s. NFPA 70, 517-20 Wet			that the deficient practice does		
	-	all receptacles and fixed			recur; All receptacles that requ	iire	
		ne area of the wet location to			GFCI protection will have and		
	_	on. Note: Moisture can reduce			maintain GFCI protection. how	V	
		ce of the body, and electrical			the corrective action(s) will be		
		ubject to failure. This deficient			monitored to ensure the deficie		
	_	t 30 residents in the main			practice will not recur, i.e., wha		
	dining room.				quality assurance program will		
					put into place; and The "Gas a		
	Findings include:				Electrical" QAPI audit tool will		
		d 161			completed by the Maintenance		
		on the Maintenance Director			Director or Designee to ensure	e all	
		5 p.m., there were two electric			receptacles that require GFCI		
	-	n 6 feet from a sink in the main			protection will have and mainta		
	-	ectric receptacle closest to the			GFCI protection. The "Gas and		
	_	ected, but the electric			Electrical" QAPI audit tool will		
	_	from the sink was not GFCI			completed weekly for one mor		
	-	ed. Based on interview at the , the Maintenance Director			and monthly for 3 months. If 10	00%	
		receptacle five feet from the			compliance is not obtained an	Th:-	
		protected and provided the			action plan will be developed.	THIS	
	measurement of five	-			information will be presented	_	
	measurement of five	e reet.			monthly to the QAPI committee	e.	
	The finding was rev	riewed with the Administrator					
	and Maintenance D	irector during the exit					
	conference.						
	3.1-19(b)						
IZ 0704							
K 0761							
SS=E							
Bldg. 01	#1 \ D	and the state of	17.0= 41	.			00/02/2022
		vation and interview, the	K 0761	l	·p paraid="1048304453"	15 -1	08/23/2023
	-	sure 1 of 4 smoke barrier doors			paraeid="{0361d5be-97b3-474	ı5-a1	
		ted and repaired as part of the			c9-0fa8aef3ab8b}{46}" >what		
	-	e program. This deficient t 33 residents in two smoke			corrective action(s) will be	nto	
		t 33 residents in two smoke			accomplished for those reside		
	compartments.				found to have been affected by	y ine	
	Findings include:				deficient practice;		
	1 manigo merade.		- 1	ı			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	III TIPI E CO	ONSTRUCTION	(X3) DATE	SURVEY
						ľ ′	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155322	B. W	_		07/31/	/2023
NAME OF P	ROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
					CR 800 E 92		
MAJEST	IC CARE OF WEST	ALLEN		FORT \	WAYNE, IN 46814		
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on observation	on with the Maintenance					
	Director on 07/31/2	3 at 11:37 a.m., the 200-hall					
	smoke doors were o	damaged, had a ¾ inch hole			The 200 hall smoke doors tha	t	
	through the one of t	the doors, and the astragals			were noted as damaged were		
	were falling off the	doors. Based on interview at			repaired. The oxygen transfer	and	
	the time of observat	tion, the Maintenance Director			filling room door was inspecte		
	agreed the smoke d	oors were damage and needed			and found to be in working or		
	to be repaired.						
	#2.) Based on obser	rvation, records review, and					
	· · · · · · · · · · · · · · · · · · ·	ty failed to ensure annual			how other residents having the	е	
		ng of 1 of 1 oxygen transfilling			potential to be affected by the		
	*	re completed in accordance of			same deficient practice will be		
		ommunicating openings in			identified and what corrective		
		rs required by 19.1.1.4.1 shall be			action(s) will be taken;		
	_	orridors and shall be protected					
	_	osing fire door assemblies.					
		3.) LSC 8.3.3.1 Openings					
	required to have a f	ire protection rating by Table			All residents have the potentia	al to	
	8.3.4.2 shall be prot	tected by approved, listed,			be affected by this deficient		
	labeled fire door as	semblies and fire window			practice. All smoke doors wer	е	
	assemblies and thei	r accompanying hardware,			inspected to ensure that they		
		s, closing devices, anchorage,			in good repair and working or		
	and sills in accorda	nce with the requirements of			The oxygen transfer and filling		
	NFPA 80, Standard	for Fire Doors and Other			room door was inspected and	-	
	Opening Protective	s, except as otherwise			found to be in good repair and		
	specified in this Co	de. NFPA 80 5.2.1 states fire			working order.		
	door assemblies sha	all be inspected and tested not					
	less than annually,	and a written record of the					
	_	signed and kept for inspection					
	_	80, 5.2.4.1 states fire door			what measures will be put into)	
		visually inspected from both			place and what systemic char	nges	
		overall condition of door			will be made to ensure that the	е	
	•), 5.2.4.2 states as a minimum,			deficient practice does not rec	cur;	
	the following items	shall be verified:					
	(1) No open holes of	or breaks exist in surfaces of					
	either the door or fr	rame.					
	(2) Glazing, vision	light frames, and glazing beads			All smoke barrier doors will be)	
	are intact and secur	ely fastened in place, if so			routinely inspected and repair	ed	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	ľ	JILDING	ONSTRUCTION 01	(X3) DATE COMPL 07/31 ,	LETED
NAME OF P	ROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD	-	
MAJEST	IC CARE OF WEST	ALLEN			CR 800 E 92 WAYNE, IN 46814		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	equipped.	R LSC IDENTIFYING INFORMATION		TAG	as a part of the facility		DATE
	* * *	, hinges, hardware, and			maintenance program. The or	vaen	
		eshold are secured, aligned,			transfer and filling room door		
		er with no visible signs of			be inspected and repaired		
	damage.				annually.		
	(4) No parts are mis						
	` '	do not exceed clearances					
	listed in 4.8.4 and 6						
		device is operational; that is,			how the corrective action(s) w		
		pletely closes when operated			monitored to ensure the defic		
	from the full open p	is installed, the inactive leaf			practice will not recur, i.e., wh		
	closes before the ac				quality assurance program wi	ıı be	
		are operates and secures the			put into place; and		
	door when it is in th	-					
		vare items that interfere or					
		re not installed on the door or			 The "Smoke Barrier/Hazardoเ	ıs	
	frame.				Area Doors" QAPI audit tool v		
	(10) No field modif	ications to the door assembly			be completed by the Maintena		
	have been performe	ed that void the label.			Director or Designee to ensur		
	(11) Gasketing and	edge seals, where required, are			that all such doors are functio	nal	
	-	their presence and integrity.			and tested per requirement. T	he	
	-	ice could affect 20 residents in			"Smoke Barrier/Hazardous Ar	ea	
	one smoke compart	ment.			Doors" QAPI audit tool will be		
	Findings include:				completed weekly for one mo and monthly for 3 months. If 1 compliance is not obtained ar	00%	
	Based on record rev	view of the with the			action plan will be developed.		
		for on 07/31/23 at 10:50 a.m., no			information will be presented		
		the oxygen transfilling room			monthly to the QAPI committee	ee.	
		ble for review. Based on					
	observation at 12:30	a.m. there was a one-hour fire					
		transfilling room. Based on					
		e of records review and					
		intenance Director stated the					
	fire door was not in	spected within the last year.					
	The findings were r	eviewed with the					
		Maintenance Director at the					
	evit conference	= 3001 00 000					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155322	B. WING		07/31/2023
	ROVIDER OR SUPPLIER		6050 \$	ADDRESS, CITY, STATE, ZIP COD S CR 800 E 92 WAYNE, IN 46814	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	DECLIPED IN LIVER CONDUCTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	3.1-19(b) NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by quathe conditions of 1 the patient care vinon-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care roother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the pinstalled and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3)	ent - Power Cords and ent - Power Strips and electrical equipment es that have been elified personnel and meet electronics, ent care resident rooms that ent - Power Strips for PCREE ent - UL 60601-1. Power Strips ent patient care rooms ent meet UL 1363. In electronics ent e	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ILE
	failed to ensure 1 of as a substitute for fi 400.8 state unless sp flexible cords and cas a substitute for fi	on and interview, the facility I flexible cords were not used xed wiring. NFPA-70/2011, becifically permitted in 400.7 ables shall not be used for (1) xed wiring. This deficient t up to 2 residents in room 211.	K 0920	p="" xml: paraid="187682624" paraeid="{2366af42-1628-404 0-694233b225e3}{180}">what corrective action(s) will be accomplished for those reside found to have been affected b deficient practice;	3-836 t
	Findings include:			The electrical extension cord noted to be in use in room 212	1

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	l í	JILDING	ONSTRUCTION 01	(X3) DATE : COMPL 07/31/	ETED
	ROVIDER OR SUPPLIER			6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 NAYNE, IN 46814		
(X4) ID PREFIX TAG	Based on observation Director on 07/31/2 there was an extens interview at the tim Maintenance Direct was in use in room. This finding was re	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL SELSC IDENTIFYING INFORMATION On with the Maintenance 3 at 11:44 a.m., in room 211 ion cord in use. Based on e of observation, the for agreed an extension cord 211. viewed with the Administrator irector during the exit		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY) was removed. how other residents having the potential be affected by the same deficient practice will be identified and corrective action(s) will be taken; All residents have the potential to be affected by this deficient practice. An audit was performed to ensure that no flexible cords were being use a substitute for fixed wiring. We measures will be put into place and what systemic changes who be made to ensure that the deficient practice does not recur; The maintenance directly will perform daily audits to enthat no flexible cords are being used as a substitute for fixed wiring. how the corrective action(s) will be monitored to ensure the deficient practice will perform the deficient practice on the recur, i.e., what quality assurance program will be purplace; and The "Gas and Electrical" QAPI audit tool will completed by the Maintenance Director or Designee to ensure that no flexible cords are being used as a substitute for fixed wiring. The "Gas and Electrical" QAPI audit tool will completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and Electrical" QAPI audit tool will be completed by the Maintenance of the "Gas and	to ient what sas das what se vill ctor sure g will t into be e g g al" eted o This	(X5) COMPLETION DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322		UILDING	nstruction 01	(X3) DATE COMPI 07/31	
	PROVIDER OR SUPPLIER		•	6050 S	DDRESS, CITY, STATE, ZIP COD CR 800 E 92 VAYNE, IN 46814		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
K 0923	NFPA 101	CESCIDENTI TING IN CHAINTICH		1710			DATE
SS=E		Cylinder and Container					
Bldg. 01	Storag	Cyllider and Container					
Diag. 01	_	Cylinder and Container					
	_	qual to 3,000 cubic feet					
		are designed, constructed,					
	_	accordance with 5.1.3.3.2					
	and 5.1.3.3.3.	accordance with 5.1.5.5.2					
	>300 but <3,000 c	ruhic feet					
		are outdoors in an					
	_	n an enclosed interior					
		mited- combustible					
	'	door (or gates outdoors)					
		ed. Oxidizing gases are not					
		ables, and are separated					
		s by 20 feet (5 feet if					
		closed in a cabinet of					
		onstruction having a					
		re protection rating.					
		Il to 300 cubic feet					
	· ·	compartment, individual					
		e for immediate use in					
	patient care areas	with an aggregate volume					
	of less than or equ	ual to 300 cubic feet are not					
	required to be stor	red in an enclosure.					
	Cylinders must be	handled with precautions					
	as specified in 11.	6.2.					
	A precautionary si	ign readable from 5 feet is					
	on each door or g	ate of a cylinder storage					
	room, where the s	ign includes the wording as					
		FION: OXIDIZING GAS(ES)					
	STORED WITHIN						
		d so cylinders are used in					
		y are received from the					
		ylinders are segregated					
	I -	. When facility employs					
	1 -	gral pressure gauge, a					
	1	e considered empty is					
	established. Emp	ty cylinders are marked to					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155322	B. W	ING	_	07/31	/2023
	PROVIDER OR SUPPLIER			6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	NIE.	DATE
	avoid confusion. Care protected from 11.3.1, 11.3.2, 11.99) #1.) Based on obser facility failed to ens nonflammable gase: properly secured from Care Facilities Code states storage for not than 8.5 cubic meters (30 11.3.2.1 through 11 11.3.2.6 states cyling comply with 11.6.2. freestanding cylinder or supported in a properly deficient praction one smoke compart. Findings include: Based on observation Director on 07/31/2 oxygen cylinders we floor of the oxygen were not properly deproper cylinder stan at the time of observation of the oxygen cylinder stan	Cylinders stored in the open in weather. 3.3, 11.3.4, 11.6.5 (NFPA) Evation and interview, the sure 5 of 12 cylinders of its such as oxygen were of falling. NFPA 99, Health ite, 2012 Edition, Section 11.3.2 onflammable gases greater its (300 cubic feet) but less than 1000 cubic feet) shall comply with its.3.2.3. NFPA 99, Section its or container restraints shall its.3. Section 11.6.2.3(11) states its shall be properly chained oper cylinder stand or cart. it ic could affect 25 residents in ment. On with the Maintenance its at 12:31 p.m., Five 'E' type its ere standing upright on the storage/trans-filling room and its hained or supported in a indicate or cart. Based on interview evation, the Maintenance its definite its property of the maintenance its pro	K 0		p="" xml: paraid="427798405" paraeid="{acfa173a-c9d9-4f06 4-c2b05c67af27}{246}">what corrective action(s) will be accomplished for those reside found to have been affected be deficient practice; The five (5) E-type cylinders weither chained or supported in proper cylinder stand or cart. 12 full and empty oxygen cylinders were separated and marked as full or empty. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to affected by this deficient pract An audit was performed to enthat all cylinders were stored properly and separated into enand full labels. what measure will be put into place and what systemic changes will be made ensure that the deficient pract does not recur; The maintena director will perform daily audiensure that all cylinders were stored properly and separated and separated and separated and full labels. In the second proper and separated and separated and separated and separated and full labels. In the second proper and separated and separat	ents by the were a The w be be cice. sure mpty s t de to cice ance dist to d into	08/23/2023
		vation and interview, the			empty and full labels. how the	9	
	-	sure 12 of 12 full and empty			corrective action(s) will be	ont	
		ere separated and marked to nis deficient practice could			monitored to ensure the defici		
	affect up to 25 resid	-			practice will not recur, i.e., wh quality assurance program wil		
	arrect up to 23 resid	ichts in one smoke	- 1		I quality assurance program wil	ıı DC	I

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

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	OF CORRECTION	IDENTIFICATION NUMBER 155322	A. BUILDING B. WING	01	COMPLETED 07/31/2023
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD CR 800 E 92	
MAJESTI	C CARE OF WEST	ALLEN		VAYNE, IN 46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0927 SS=E Bldg. 01	compartment. Findings include: Based on observation Director on 07/31/2: storage room contain cylinders, but the cylinders at the time Maintenance Director not marked as full at the findings were read to the exit conference. 3.1-19(b) NFPA 101 Gas Equipment - Transfilling of oxyglanother is in according to the cylinder of the cylinder	ons with the Maintenance 3 at 12:31 p.m., the oxygen ned full and empty oxygen relinders were mixed together full or empty. Based on the of observation, the or stated the cylinders were and empty. Eviewed with the Maintenance Director during Transfilling Cylinders Gene from one cylinder to redance with CGA P-2.5, an Pressure Gaseous Respiration. Transfilling of cylinder to another is ant care rooms. Transfilling ontainers or to portable of psi comply with conditions NFPA 99). Transfilling to ainers or to portable of psi comply with 1.5.2.3.2 (NFPA 99).	K 0927	put into place; and The "Gas a Electrical" QAPI audit tool will completed by the Maintenance Director or Designee to ensure that all cylinders were stored properly and separated into er and full labels. The "Gas and Electrical" QAPI audit tool will completed weekly for one mor and monthly for 3 months. If 1 compliance is not obtained an action plan will be developed. information will be presented monthly to the QAPI committee monthly to the QAPI committee working and the property of the paraeid of the property of the pro	and be e e e mpty be nth, 00% This e. 08/23/2023
	separated from any	portion of a facility by the transfilling room is		corrective action(s) will be accomplished for those reside	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/31/2023	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF WEST	ALLEN		CR 800 E 92 WAYNE, IN 46814		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)		X5) LETION TE
	accordance with NF deficient practice of one smoke compart Findings include: Based on observation Director on 07/31/2 Maintenance Director oxygen transfilling placed over the strill from latching into that the time of obser Director agreed the frame and removed The finding was rev	on with the Maintenance 3 at 12:31 p.m., when the tor opened the door to the room there was a magnet strip ke plate preventing the door the frame. Based on interview vation, the Maintenance door was not latched into the		found to have been affected deficient practice; The magnet strip placed or strike pad to the oxygen transfilling room was remove allowing the door to latch in frame. How other resident having the potential to be a by the same deficient praction be identified and what correction action(s) will be taken; All residents have the potential affected by this deficient properties and transfilling door room in plakeyed lock, will allow staff that access the room with a coordinate of a key. What me will be put into place and we systemic changes will be mensure that the deficient properties that the deficient properties of the corrective action(s) will be monitored and the corrective action(s) will be monitored and the corrective action(s) will be monitored and the corrective action and the correction and the corrective action and the correction and th	ver the ed to the s ffected ce will ective to be actice. e ce of a o e assures nat adde to actice nance udits to e will out into vill be nce ure sent gen g into	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155322	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/31/2023	
	ROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COD CR 800 E 92 WAYNE, IN 46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
				weekly for one month, and monthly for 3 months. If 100% compliance is not obtained ar action plan will be developed information will be presented monthly to the QAPI committed	n . This	

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