STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. BUILDING -- B. WING	06/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/12/25 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 At this Emergency Preparedness survey, Majestic Care of West Allen was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 96 and had a census of 80 at the time of this survey. Quality Review completed on 06/16/25	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/12/25 Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600 At this Life Safety Code survey, Majestic Care of West Allen was found not in compliance with Requirements for Participation in	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zach Krumwied	Executive Director	06/27/2025

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and hard wired smoke detectors in resident rooms 310-317. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 96 and had a census of 80 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered which the exception of a detached garage used to store maintenance supplies and equipment. Quality Review completed on 06/16/25			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 1 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or	K 0353	**K 353** *What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* **-An additional internal sprinkler pipe inspection was scheduled and completed with subsequent or recommended flush as indicated.** *How other residents having the potential to be affected by the same deficient practice will be*	06/28/2025

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	sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on records review with the Maintenance Director and the Administrator on 06/12/25 at 10:50 a.m. and at 1:30 p.m., the Internal Pipe Inspection report dated 09/26/24 stated "Rust Found " and a quote was sent on 02/13/25 to flush the system. There was documentation showing about 75% of the sprinkler piping has been replaced after 09/26/24. Although, there was no documentation to show if the remaining 25% of existing sprinkler piping still needed to be flushed. Based on interviews at 10:50 a.m. and at 1:30 p.m., the Maintenance Director and the Administrator both stated the failed piping was replaced and another internal pipe inspection would be scheduled to see if the existing piping still needed to be flushed or repaired. This finding was reviewed with the Administrator and Maintenance Director during the exit conference at 1:45 p.m. 3.1-19(b)		*identified and what corrective action(s) will be taken?* ***-The* sprinkler system will have its 5 year inspection timely and a subsequent flush will be performed as directed.** *What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur?* **-The maintenance director was educated on ensuring that sprinkler system has its 5 year inspection timely and that a subsequent flush is performed as directed.** *How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place)* **-Upon completion of the initial education with the Maintenance Director, the Executive Director will monitor the performance of sprinkler pipe maintenance and inspections and present compliance to the QAPI committee on a monthly basis. Additional education will be provided as needed.** *By what date the systematic change for each deficiency will be completed*	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility	K 0363	**K 363**	06/28/2025

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	failed to ensure both leaves on 1 of 1 Dutch doors latched into the frame in accordance with LSC 19.3. Section 19.3.6.3.13 states Dutch doors shall be permitted where they conform to 19.3.6.3 and meet all of the following criteria: (1) Both the upper leaf and lower leaf are equipped with a latching device. (2) The meeting edges of the upper and lower leaves are equipped with an astragal, a rabbet, or a bevel. (3) Where protecting openings in enclosures around hazardous areas, the doors comply with NFPA80, Standard for Fire Doors and Other Opening Protectives. This deficient practice could affect 2 residents in room 116. Findings include: Based on observation with the Maintenance Director on 06/12/24 at 12:10 p.m., room 116 was provided with a Dutch door with independent closing top and bottom leaves. When tested the bottom leaf did latch into the frame but the top leaf did not. Also, the meeting edges of the upper and lower leaves were not equipped with an astragal, a rabbet, or a bevel. Based on an interview at 12:10 p.m., the Maintenance Director agreed the top leaf of the Dutch door did not latch into the door frame when tested and was not provided with an astragal, a rabbet, or a bevel. This finding was reviewed with the Administrator and Maintenance Director during the exit conference at 1:45 p.m. 3.1-19(b)		*What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* **-The door at the entrance 116 was repaired to ensure that it latches when tested and was provided with astragal to ensure compliance.** *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 remaining Dutch doors will be ensured to meet specifications and compliance.** *What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur?* **-The maintenance director was in-serviced on the importance of maintaining that all doors latch and meet specifications.** *How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place)* **-The Maintenance Director will bring results of rounds related to room entry doors to the QAPI meeting monthly to discuss with the QA team and monitor for compliance.** *By what date the systematic change for each deficiency will be completed*	

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K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure 1 of 4 smoke barrier doors were properly inspected and repaired as part of the facility maintenance program. LSC section 19.7.6 Maintenance and Testing states See 4.6.12. Section 4.6.12.4 states any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in the code. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. This deficient practice could affect 45 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 06/12/24 at 12:30 p.m., the service hall smoke doors were damaged and had four, 1-inch size holes that went halfway through the doors. Based on records review at 11:32 a.m., the fire/smoke door inspection documentation dated 05/04/25, listed the service hall smoke door as "PASSED." Based on an interview at 12:30 p.m., the Maintenance Director agreed there were holes in the smoke doors and the door inspection did not list the damage to the door. This finding was reviewed with the Administrator	K 0761	**K 761** *What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* **-The service hall smoke doors were repaired to ensure that to ensure that they pass inspection and meet requirements.** *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 smoke doors were inspected to ensure that they are in good repair and meet requirements and specifications.** *What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur?* **-The Maintenance director will perform monthly audits for three months and annually thereafter to ensure compliance is maintained.** *How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place)* **-The Maintenance Director will bring results of the audits to the QAPI meeting monthly to**	06/28/2025

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	and Maintenance Director during the exit conference at 1:45 p.m. 3.1-19(b)		**discuss the QA team and monitor for compliance.** *By what date the systematic change for each deficiency will be completed*	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review and interview, the facility failed to ensure 25 of 25 Patient Care Related Electrical Equipment (PCREE) were retested after being replaced. NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents.	K 0921	**K 921** *What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?* **-All items that failed the PCREE testing were either repaired , removed, or replaced with additional testing.** *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 items that fail subsequent PCREE testing will be either repaired , removed, or replaced with additional testing.** *What measures will be put into place and what systematic changes will be made to ensure that the deficient will not recur?* **The Maintenance director will perform monthly audits to ensure all items that fail a PECREE test are either repaired , removed, or replaced with additional testing.**	06/28/2025

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	Findings include: Based on records review with the Maintenance Director on 06/12/25 at 11:19 a.m., the PCREE testing documentation dated 04/15/25 indicated 25 PCREE items failed testing. No documentation was available for review to show if the PCREE was repaired or replaced and retested after repairs or replacement. Based on interviews at 11:19 a.m., the Maintenance Director stated failed items were replaced but not documented and also stated, the replacement PCREE items were not tested when put into service. This finding was reviewed with the Administrator and Maintenance Director during the exit conference at 1:45 p.m. 3.1-19(b)		*How the corrective actions will be monitored to ensure the deficient practice will not recur (what quality assurance program will be put into place)* **-The Maintenance Director will bring results of the audits to the QAPI meeting monthly to discuss the QA team and monitor for compliance.** *By what date the systematic change for each deficiency will be completed*	