PRINTED:	12/16/2021
FORM APE	PROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155359		(X2) MULTIPLE CC A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021
	PROVIDER OR SUPPLIED		7519 W	ADDRESS, CITY, STATE, ZIP COD INCHESTER RD VAYNE, IN 46819	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR(ION (X5) D BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	conducted by the II accordance with 42 Survey Date: 11/29 Facility Number: 0 Provider Number: AIM Number: 1002 At this Emergency Care of Fort Wayne with Emergency Pr Medicare and Med and Suppliers, 42 C capacity of 66 and of this survey.	9/21 00250 155359 289980 Preparedness survey, Majestic e was found not in compliance reparedness Requirements for icaid Participating Providers CFR 483.73. The facility has a had a census of 60 at the time	E 0000		
E 0004 SS=C Bldg	S=C 441.184(a), 482.15(a), 483.475(a), 483.73(a),				

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

TITLE

(X6) DATE

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.

FU8D21 Facility ID: 000250

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLI		7519 V	ADDRESS, CITY, STATE, ZIP COD		
IVIAJES	FIC CARE OF FOR	I WATNE	FORT	WAYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETIC DATE
	comprehensive a program that me section. The ema program must in the following elect (a) Emergency F develop and mai preparedness pla and updated at la must do all of the * [For hospitals a §485.625(a):] En or CAH] must co Federal, State, a preparedness re CAH] must deve comprehensive a program that me section, utilizing * [For LTC Facilii Emergency Plan develop and mai preparedness pla and updated at la * [For ESRD Fac Emergency Plan develop and mai preparedness pla	Plan. The [facility] must ntain an emergency an that must be [reviewed], east every 2 years. The plan e following: at §482.15 and CAHs at nergency Plan. The [hospital mply with all applicable ind local emergency quirements. The [hospital or lop and maintain a emergency preparedness ets the requirements of this an all-hazards approach. ties at §483.73(a):] . The LTC facility must ntain an emergency an that must be reviewed,				
	failed to review an Preparedness Plan	eview and interview, the facility nd update the Emergency (EPP) at least annually in 2 CFR 483.73(a). This deficient	E 0004	What corrective action(s) be accomplished for those residents found to have be affected by the deficient	•	12/10/20

	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	(X2) MULTIPLE C A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021
	PROVIDER OR SUPPLIE		7519 V	ADDRESS, CITY, STATE, ZIP CO VINCHESTER RD WAYNE, IN 46819	D
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C practice could affe Findings include: Based on records r and the Maintenan a.m., no document EPP was reviewed year. Based on an review, the Admin documentation to s updated within the This finding was r	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION ext all occupants. The preview with the Administrator ace Director on 11/29/21 at 10:41 fation was provided to show the and updated within the last interview during records histrator stated there was no show the EEP was reviewed and	ID PREFIX TAG	PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) practice; On 12/10/21 the Mainte Director/designee updat EPP and the IDT review accuracy and signed. How other residents ha potential to be affected same deficient practice identified and what con action(s) will be taken; Resident's that reside in facility have the potentia affected. The EPP was audited to applicable preventative maintenance items and emergency preparednes; have been completed of by the Executive Director/Designee. What measures will be place and what system changes will be made to ensure that the deficient practice does not recu All staff were educated of by the Executive Director/Designee on 12 The EPP will be reviewed by the Executive Director/Designee to en compliance. How the corrective act will be monitored to en deficient practice will r recur, i.e., what quality assurance program will into place; QAPI tool EPP will be con	DULD BE PROPRIATE COMPLETION DATE DATE nance DATE aving the DATE be will be DATE aving the DATE be mot DATE

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7519 \	ADDRESS, CITY, STATE, ZIP CO WINCHESTER RD WAYNE, IN 46819	D		
(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 CORR. (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
TAG 5 0006 SS=F Bldg	403.748(a)(1)-(2) (1)-(2), 441.184(a 483.475(a)(1)-(2) (1)-(2), 485.625(a 485.727(a)(1)-(2) 486.360(a)(1)-(2) (1)-(2) Plan Based on A §403.748(a)(1)-(2) §448.113(a)(1)-(2) §483.73(a)(1)-(2) §483.73(a)(1)-(2) §485.625(a)(1)-(2) §485.625(a)(1)-(2) §485.920(a)(1)-(2) §491.12(a)(1)-(2)	R LSC IDENTIFYING INFORMATION (4)(1)-(2), 418.113(a) (a)(1)-(2), 482.15(a)(1)-(2), (483.73(a)(1)-(2), 484.102(a) (a)(1)-(2), 485.68(a)(1)-(2), (485.920(a)(1)-(2), (491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment (2), §416.54(a)(1)-(2), (3)(441.184(a)(1)-(2), (3)(482.15(a)(1)-(2), (3)(483.475(a)(1)-(2), (3)(485.68(a)(1)-(2), (3)(485.68(a)(1)-(2), (3)(485.727(a)(1)-(2), (3)(485.727(a)(1)-(2), (3)(486.360(a)(1)-(2), (3)(486.360(a)(1)-(2), (4)(486.360(a)(1)-(2),	TAG	weekly X 4 weeks, bi-m and monthly X 4 months Executive Director/Desi 100% threshold is not a action plan will be devel information will be prese the QAPI committee dur monthly meeting.	onthly X 2 s by gnee If chieved an loped. This ented to	DATE	
	develop and main preparedness pla and updated at le must do the follow	ntain an emergency In that must be reviewed, east every 2 years. The plan wing:]					
	facility-based and	and include a documented, l community-based risk zing an all-hazards					
		gies for addressing is identified by the risk					

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021	
	NAME OF PROVIDER OR SUPPLIER		STREET 7519 V	DD		
	1			WAYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE
	Plan. The Hospin maintain an emer that must be revi every 2 years. The following: (1) Be based on facility-based an assessment, util approach. (2) Include strate emergency even assessment, include consequence disasters, and of affect the hospic *[For LTC facilitie Emergency Plan develop and mai preparedness plan and updated at la do the following: (1) Be based on facility-based an assessment, util approach, include (2) Include strate emergency even assessment. *[For ICF/IIDs att Plan. The ICF/IID an emergency p be reviewed, and years. The plan	at §418.113(a):] Emergency ce must develop and regency preparedness plan iewed, and updated at least he plan must do the and include a documented, d community-based risk izing an all-hazards egies for addressing its identified by the risk luding the management of es of power failures, natural ther emergencies that would e's ability to provide care. es at §483.73(a):] . The LTC facility must intain an emergency an that must be reviewed, east annually. The plan must and include a documented, d community-based risk izing an all-hazards ing missing residents. egies for addressing its identified by the risk §483.475(a):] Emergency D must develop and maintain reparedness plan that must d updated at least every 2 must do the following: and include a documented, d community-based risk				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7519 V	ADDRESS, CITY, STATE, ZIP COD VINCHESTER RD WAYNE, IN 46819		
INIAJES	TO CARE OF FOR	T WATNE	FORT	WATNE, IN 40819		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E (X5) COMPLETION DATE	
	approach, includ (2) Include strate emergency even assessment. Based on record re failed to maintain Plan (EPP) that we documented, facil risk assessment, u including missing strategies for addr identified by the r with 42 CFR 483. This deficient prace Findings include: Based on records and the Maintenar a.m., no document a documented faci community-based all-hazards approa- time of record rev risk assessment ut could not be found The finding was re-	risk assessment utilizing an uch. Based on interview at the iew, the Administrator stated a ilizing an all-hazards approach	E 0006	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/10/21 the Maintenance Director/designee updated the EPP to ensure that it included a facility-based and community-based risk assessment utilizing an all-hazards approach. 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; Resident's that reside in the facility have the potential to be affected. The EPP was audited to ensure that there is a facility-based and community-based risk assessment utilizing an all-hazards approach on 12/10/ by the Executive Director/Designee. What measures will be put int place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were educated on the	ne e e d	

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		СОМ	e survey pleted 19/2021	
	PROVIDER OR SUPPLIE			7519 V	ADDRESS, CITY, STATE, ZIP CO VINCHESTER RD WAYNE, IN 46819	D	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY) need for and utilization	OULD BE PPROPRIATE	(X5) COMPLETION DATE
E 0013 SS=C Bldg	441.184(b), 482. 484.102(b), 485.9 485.727(b), 485.9 491.12(b), 494.62 Development of R §403.748(b), §41 §441.184(b), §46 §483.73(b), §483 §485.68(b), §485 §485.920(b), §48 §494.62(b). (b) Policies and p develop and impl preparedness po	54(b), 418.113(b), 15(b), 483.475(b), 483.73(b), 525(b), 485.68(b), 520(b), 485.68(b), 520(b), 486.360(b), 2(b) EP Policies and Procedures 6.54(b), §418.113(b), 0.84(b), §482.15(b), .475(b), §484.102(b), .625(b), §485.727(b), 6.360(b), §491.12(b), 5.360(b), §491.12(b), §491.12(b), §491.12(b), §491.12(b), §491.12(b), §491.12(b), §491.12(b), §491.12(b)			by the Executive Director/Designee on 12 The EPP will be review by the Executive Director/Designee to en compliance. How the corrective act will be monitored to en deficient practice will n recur, i.e., what quality assurance program wi into place; QAPI tool EPP will be c weekly X 4 weeks, bi-m and monthly X 4 month Executive Director/Desi 100% threshold is not a action plan will be deve information will be prese the QAPI committee du monthly meeting.	2/8/21. ed weekly asure tion(s) asure the not v II be put completed conthly X 2 s by ignee If achieved an loped. This ented to	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/29/2021 155359 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7519 WINCHESTER RD MAJESTIC CARE OF FORT WAYNE FORT WAYNE. IN 46819 (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 (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and **ESRD** Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies FU8D21 Facility ID: 000250 Page 8 of 55 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

12/16/2021

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		<u></u>	(X3) DATE SURVEY COMPLETED 11/29/2021
	PROVIDER OR SUPPLIEF			7519 V	ADDRESS, CITY, STATE, ZIP COD VINCHESTER RD WAYNE, IN 46819	
(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) COMPLE DATE
	and procedures. develop and imple preparedness polit on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The polito be reviewed and u years. These emer- not limited to, fire, failures, care-relati- supply interruption likely to occur in the area. Based on record rev- failed to review and Preparedness Plan (at least annually in 483.73(a). This defi- occupants. Findings include: Based on records re- and the Maintenance a.m., no documenta EPP policies and pr updated within the interview during re- stated there was no EEP policies and pr updated within the This finding was re-	The dialysis facility must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 rgencies include, but are equipment or power ted emergencies, water n, and natural disasters ne facility's geographic view and interview, the facility update the Emergency EPP) policies and procedures accordance with 42 CFR teient practice could affect all eview with the Administrator e Director on 11/29/21 at 10:41 tion was provided to show the ocedures were reviewed and last year. Based on an cords review, the Administrator documentation to show the ocedures were reviewed and	E 00		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/10/21 the Maintenance Director/designee updated the EPP to ensure that it included policies and procedures regard the EPP and that they were reviewed. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Resident's that reside in the facility have the potential to be affected. The EPP was audited to ensure that it includes policies and procedures regarding the EPP that they were reviewed on 12/10/21 by the Executive	l 12/10/2 n ding he e e re

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDI		-		OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7519 \	r address, city, state, zip cod WINCHESTER RD r WAYNE, IN 46819	•	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
				Director/Designee. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were educated on the need for and utilization of the by the Executive Director/Designee on 12/8/21 The EPP will be reviewed we by the Executive Director/Designee to ensure compliance. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be p into place; QAPI tool EPP will be complet weekly X 4 weeks, bi-monthly and monthly X 4 months by Executive Director/Designee 100% threshold is not achieve action plan will be presented the QAPI committee during the monthly meeting.	e EPP ekly the out vted vX 2 lf ed an This to	
E 0018 SS=C Bldg	and (v), 441.184 483.475(b)(2), 48 485.920(b)(1), 48 Procedures for T §403.748(b)(2), § (ii) and (v), §441 §482.15(b)(2), §4	 16.54(b)(1), 418.113(b)(6)(ii) (b)(2), 482.15(b)(2), 33.73(b)(2), 485.625(b)(2), 36.360(b)(1), 494.62(b)(1) racking of Staff and Patients 416.54(b)(1), §418.113(b)(6) 184(b)(2), §460.84(b)(2), 483.73(b)(2), §483.475(b)(2), 485.920(b)(1), §486.360(b) 				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021	
	NAME OF PROVIDER OR SUPPLIER		7519 W	ADDRESS, CITY, STATE, ZIP COD		
MAJES	TIC CARE OF FOR	TWAYNE	FORT	WAYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRC DEFICIENCY)) BE	(X5) COMPLETIO DATE
mo	(1), §494.62(b)(1					DATE
	must develop an preparedness por on the emergence (a) of this section paragraph (a)(1) communication p section. The poli reviewed and up [annually for LTC the policies and p the following:] [(2) or (1)] A syst on-duty staff and [facility's] care du on-duty staff and relocated during must document to location of the re- location.	procedures. The [facilities] d implement emergency licies and procedures, based cy plan set forth in paragraph n, risk assessment at of this section, and the blan at paragraph (c) of this cies and procedures must be dated at least every 2 years c facilities]. At a minimum, procedures must address the track the location of sheltered patients in the uring an emergency. If sheltered patients are the emergency, the [facility] he specific name and ceiving facility or other				
	§483.73(b), ICF/ §460.84(b):] Poli system to track t and sheltered rea ICF/IID or PACE emergency. If ou residents are rela emergency, the [PACE] must doc and location of th location. *[For Inpatient H- Policies and proc	IIDs at §483.475(b), PACE at cies and procedures. (2) A he location of on-duty staff sidents in the [PRTF's, LTC,] care during and after an h-duty staff and sheltered boated during the PRTF's, LTC, ICF/IID or ument the specific name he receiving facility or other				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7519 V	STREET ADDRESS, CITY, STATE, ZIP COD 7519 WINCHESTER RD FORT WAYNE, IN 46819		
				1		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC	
	needs of evacue transportation; id location(s) and p of communication assistance. (v) A system to tu employees' on-d the hospice's car the on-duty empl are relocated dur hospice must dor and location of th location. *[For CMHCs at procedures. (2) \$ CMHC, which ind and treatment ner responsibilities; to of evacuation loc alternate means external sources *[For OPOs at § procedures. (2) A documentation th actual donor info confidentiality of information, and availability of rec *[For ESRD at § procedures. (2) S dialysis facility, w responsibilities, a Based on record re failed to ensure en and procedures ind	486.360(b):] Policies and A system of medical nat preserves potential and rmation, protects potential and actual donor secures and maintains the	E 0018	What corrective action(s) v be accomplished for those residents found to have be affected by the deficient)	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155359	A. BUILDING B. WING		COMPLETED 11/29/2021
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD	
MAJEST	IC CARE OF FOR	T WAYNE		WINCHESTER RD WAYNE, IN 46819	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETIC DATE
		's care during and after an		practice;	
	-	duty staff and sheltered		On 12/10/21 the Maintenance	
		ated during the emergency, the		Director/designee updated the	
		document the specific name and		EPP to ensure that it included	
		eiving facility or other location		documentation of a system to	
		n 42 CFR 483.73(b) (2). This		track the location of on-duty sta	aff
		could affect all occupants,		and sheltered residents in the	
		*		facility's care during an	
	Findings include:			emergency.	
				How other residents having the	ne
	Based on records	review with the Administrator		potential to be affected by the	
	and the Maintenar	nce Director on 11/29/21 at 10:51		same deficient practice will be	
	a.m., documentati	on of a system to track the		identified and what corrective)
	location of on-dut	y staff and sheltered residents		action(s) will be taken;	
	in the facility's car	e during an emergency was not		Resident's that reside in the	
	provided. Based o	n interview at the time of record		facility have the potential to be	
	review, the Admir	nistrator stated a staff and		affected.	
	resident tracking p	policy could not be found.		The EPP was audited to ensure	e
				that it includes documentation	ofa
	The finding was re	eviewed with the Administrator		system to track the location of	
	and Maintenance	Director at the exit conference.		on-duty staff and sheltered	
				residents in the facility's care	
				during an emergency. on 12/10)/21
				by the Executive	
				Director/Designee.	
				What measures will be put int	.o
				place and what systemic	
				changes will be made to	
				ensure that the deficient	
				practice does not recur;	
				All staff were educated on the	
				need for and utilization of the E	.PP
				by the Executive	
				Director/Designee on 12/10/21	
				The EPP will be reviewed week	dy
				by the Executive	
				Director/Designee to ensure	
				compliance.	
				How the corrective action(s)	
				will be monitored to ensure th	ie

GTATENENT OF DEFICIENCIES			ONGEDUCTION		CLUDINEN
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	x1) provider/supplier/clia identification number 155359	(X2) MULTIPLE C A. BUILDING B. WING	<u></u>	(X3) DATE SURVEY COMPLETED 11/29/2021	
NAME OF PROVIDER OR SUPPLE MAJESTIC CARE OF FOR		7519 V	ADDRESS, CITY, STATE, ZIP COD WINCHESTER RD WAYNE, IN 46819		
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DE PRIATE	(X5) COMPLETION DATE
SS=C 441.184(b)(3), 4 Bldg 483.73(b)(3), 48 485.727(b)(1), 4 494.62(b)(2) Policies for Evac §403.748(b)(3), (ii), §441.184(b) (3), §483.73(b)(3) (1), §485.625(b) §485.920(b)(2), [(b) Policies and must develop an preparedness po on the emergend (a) of this section paragraph (a)(1) communication p section. The poli reviewed and up [annually for LTC	16.54(b)(2), 418.113(b)(6)(ii), 82.15(b)(3), 483.475(b)(3), 5.625(b)(3), 485.68(b)(1), 85.920(b)(2), 491.12(b)(1), c. and Primary/Alt. Comm. §416.54(b)(2), §418.113(b)(6) (3), §460.84(b)(3), §482.15(b) 3), §483.475(b)(3), §485.68(b) (3), §485.727(b)(1), §491.12(b)(1), §494.62(b)(2) procedures. The [facilities] id implement emergency blicies and procedures, based cy plan set forth in paragraph n, risk assessment at of this section, and the blan at paragraph (c) of this cies and procedures must be idated at least every 2 years C facilities]. At a minimum, procedures must address		deficient practice will not recur, i.e., what quality assurance program will b into place; QAPI tool EPP will be com weekly X 4 weeks, bi-mont and monthly X 4 months by Executive Director/Designe 100% threshold is not achi action plan will be develop information will be present the QAPI committee during monthly meeting.	e put pleted hly X 2 y ee If eved an ed. This ed to	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED 11/29/2021		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7519 WINCHESTER RD				
MAJES	MAJESTIC CARE OF FORT WAYNE		FOR	T WAYNE, IN 46819				
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETIC		
TAG	[facility], which in and treatment ne responsibilities; t of evacuation loc alternate means external sources *[For RNHCIs at §416.54(b)(2):] Safe evacuation which includes th (i) Consideration (ii) Staff responsi (iii) Transportation (iv) Identification (v) Primary and a communication v assistance. * [For CORFs at Rehabilitation Ag §485.727(b)(1), a §494.62(b)(2):] Safe evacuation Rehabilitation Ag Agencies as Pro Therapy and Spe Services; and ES includes staff res the patients. * [For RHCs/FQF evacuation from includes approprist failed to ensure en	§403.748(b)(3) and ASCs at from the [RNHCI or ASC] he following: of care needs of evacuees. bilities.	Е 0020	What corrective action(s) be accomplished for those residents found to have be	e	DATE		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPI A. BUILDIN	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		155359	B. WING		11/29/2021	
NAME OF	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP CC 19 WINCHESTER RD	D	
MAJEST	IC CARE OF FOR	TWAYNE		RT WAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	ί.	NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE AP	OULD BE COM	MPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY)		DATE
		are and treatment needs of		practice;		
		ponsibilities; transportation;		The policy and procedu		
		vacuation location(s); and		addressing safe evacua		
		ate means of communication		added to the EOP on 12		
		ces of assistance in accordance		How other residents ha	-	
		73(b) (3). This deficient practice		potential to be affected	-	
	could affect all oc	cupants.		same deficient practice		
				identified and what co	rrective	
	Findings include:			action(s) will be taken;		
				All residents that reside		
		eview with the Administrator		facility have the potentia	al to be	
		ce Director on 11/29/21 at 10:52		affected by the deficient	practice.	
		on of a system to evacuate from		The Executive Director	was	
		an emergency was not		educated on where to lo	ocate the	
	-	n interview at the time of record		Evacuation policy and p	rocedure	
		istrator stated a facility		by the Regional Vice Pr		
	evacuation policy	could not be found.		Operations on 12/10/21	. These	
				documents were added		
		eviewed with the Administrator		Emergency Operations	Manual on	
	and Maintenance I	Director at the exit conference.		12/10/21.		
				What measures will be	put into	
				place and what system		
				changes will be made		
				ensure that the deficie	nt	
				practice does not recu	r;	
				The Emergency Operat		
				will be reviewed annual		
				minimum to ensure all r	-	
				policies, procedures and		
				documentation are pres		
				All staff was educated o		
				by the Executive Directo	or on	
				12/10/21.		
				How the corrective act		
				will be monitored to er		
				deficient practice will r		
				recur, i.e., what quality		
				assurance program wi	ll be put	
				into place;		
				QAPI tool EPP will be c	ompleted	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION		E SURVEY PLETED	
		155359	B. WING		11/2	11/29/2021	
NAME OF	PROVIDER OR SUPPLIE	R		r address, city, state, zip co WINCHESTER RD	D		
MAJEST	IC CARE OF FOR	TWAYNE	FORT	WAYNE, IN 46819			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	FROFRIATE	DATE	
				weekly X 4 weeks, bi-mand monthly X 4 months Executive Director/Design 100% threshold is not an action plan will be devel information will be present the QAPI committee dur monthly meeting.	s by gnee If chieved an oped. This ented to		
E 0022 SS=C Bldg	441.184(b)(4), 48 483.73(b)(4), 485 485.727(b)(2), 48 494.62(b)(3) Policies/Procedu §403.748(b)(4), § (i), §441.184(b)(4 (4), §483.73(b)(4 (2), §485.625(b)(§485.920(b)(3), § (b) Policies and p must develop and preparedness po on the emergenc (a) of this section paragraph (a)(1) communication p section. The poli be reviewed and years [annually for minimum, the pol address the follow [(4) or (2),(3),(5), place for patients remain in the [fac	(6)] A means to shelter in , staff, and volunteers who illity]. ospices at §418.113(b):]					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/29/2021 155359 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7519 WINCHESTER RD MAJESTIC CARE OF FORT WAYNE FORT WAYNE. IN 46819 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. Based on record review and interview, the facility E 0022 12/10/2021 What corrective action(s) will failed to ensure emergency preparedness policies be accomplished for those and procedures include information for safe residents found to have been evacuation from the LTC facility, which includes affected by the deficient consideration of care and treatment needs of practice; evacuees; staff responsibilities; transportation; The policy addressing a system to identification of evacuation location(s); and shelter in place for patients, staff primary and alternate means of communication and volunteers who remain in the with external sources of assistance in accordance facility during an emergency was with 42 CFR 483.73(b) (3). This deficient practice added to the EOP on 12/10/21. could affect all occupants. How other residents having the potential to be affected by the Findings include: same deficient practice will be identified and what corrective Based on records review with the Administrator action(s) will be taken; and the Maintenance Director on 11/29/21 at 10:53 All residents that reside in the a.m., documentation of a system to shelter in place facility have the potential to be for patients, staff, and volunteers who remain in affected by the deficient practice. the facility during an emergency was not The Executive Director was provided. Based on interview at the time of record educated on where to locate the review, the Administrator stated a facility shelter Shelter in Place policy and in place policy could not be found. procedure by the Regional Vice President of Operations on The finding was reviewed with the Administrator 12/10/21. These documents were and Maintenance Director at the exit conference. added to the Emergency Operations Manual on 12/10/21. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Event ID: FU8D21 Facility ID: 000250 Page 18 of 55 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

12/16/2021

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		СОМ	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7519	ET ADDRESS, CITY, STATE, ZIP COD WINCHESTER RD T WAYNE, IN 46819			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ION D BE OPRIATE	(X5) COMPLETION DATE	
E 0029 SS=F Bldg	403.748(c), 416.9 441.184(c), 482.7 484.102(c), 485.9 485.727(c), 485.9 491.12(c), 494.62 Development of (§403.748(c), §41 §441.184(c), §46 §483.73(c), §483 §485.68(c), §483 §485.68(c), §485 §485.920(c), §485 §485.920(c), §485 §485.920(c), §485 §485.920(c), §485 §485.920(c), §485 §494.62(c). (c) The [facility] n an emergency pr plan that complie local laws and m at least every 2 y facilities].	54(c), 418.113(c), 15(c), 483.475(c), 483.73(c), 525(c), 485.68(c), 920(c), 486.360(c),	E 0029	The Emergency Operation will be reviewed annually minimum to ensure all rec policies, procedures and documentation are preser All staff was educated on by the Executive Director 12/10/21 How the corrective actio will be monitored to ensu- deficient practice will no recur, i.e., what quality assurance program will I into place; The EOP will be reviewed annually in the QAPI mee updated as needed. All s be educated upon hire an minimum annually on the What corrective action(s	at a juired nt. the EOP on n(s) ure the t be put d ting and taff will d at a EOP.	12/10/202	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE COMPL	ETED	
NAMEOE	PROVIDER OR SUPPLIE			ET ADDRESS, CITY, STATE, ZIP CO		11/29/2021	
	TIC CARE OF FOR) WINCHESTER RD T WAYNE, IN 46819			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	and procedures inc evacuation from the consideration of ca evacuees; staff res- identification of ev primary and altern with external source with 42 CFR 483.7 could affect all occ Findings include: Based on records r and the Maintenan a.m., the provided communication plat time of record revis facility communication The finding was records r	ergency preparedness policies dude information for safe e LTC facility, which includes are and treatment needs of ponsibilities; transportation; vacuation location(s); and ate means of communication ces of assistance in accordance 73(b) (3). This deficient practice cupants. eview with the Administrator ce Director on 11/29/21 at 10:55 EPP did not include a written an. Based on interview at the ew, the Administrator stated the ation plan could not be found. eviewed with the Administrator Director at the exit conference.		 be accomplished for the residents found to have affected by the deficient practice; Emergency preparedness and procedures were up the written Communication 12/10/21. How other residents had potential to be affected same deficient practice identified and what corraction(s) will be taken; All residents that reside facility have the potential affected by the deficient The Executive Director we educated on where to low written Communication F the Regional Vice Preside Operations on 12/10/21. What measures will be place and what system changes will be made the ensure that the deficient The Emergency Operations on 12/10/21. What measures will be made the ensure that the deficient The Emergency Operations on 12/10/21. What measures will be made the ensure that the deficient practice does not recurrate the the the fiction of the Emergency Operations on 12/10/21. What measures will be made the ensure that the deficient practice does not recurrate the the fiction of the Emergency Operation of the	e been at as policies odated with tion Plan aving the by the e will be rective in the il to be practice. was cate the Plan by dent of . These to the Manual on put into ic o nt r; ons Plan y at a equired d ent. n the EOP		
				12/10/21. How the corrective acti will be monitored to en deficient practice will n	sure the		

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7519	T ADDRESS, CITY, STATE, ZIP C WINCHESTER RD T WAYNE, IN 46819	OD		
(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 S) CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
0036	403 748(4) 416 4	-4(d) 419 112(d)		recur, i.e., what qualit assurance program w into place; The EOP will be review in the QAPI meeting ar as needed. All staff wi educated upon hire an minimum annually on t	ill be put ved annually nd updated II be d at a		
SS=F Bldg	484.102(d), 485.6 485.727(d), 485.9 491.12(d), 494.62 EP Training and §403.748(d), §41 §441.184(d), §46 §483.73(d), §483 §485.68(d), §485	15(d), 483.475(d), 483.73(d), 625(d), 485.68(d), 620(d), 486.360(d), 2(d)					
	Hospice at §418. PACE at §460.84 HHAs at §484.10 CAHs at §486.62 485.727, CMHCs §486.360, and RI Training and testi develop and main preparedness tra that is based on t in paragraph (a) of assessment at para section, policies a	§403.748, ASCs at §416.54, 113, PRTFs at §441.184, 4, Hospitals at §482.15, 2, CORFs at §485.68, 5, "Organizations" under 4 at §485.920, OPOs at HC/FHQs at §491.12:] (d) ing. The [facility] must intain an emergency ining and testing program he emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at paragraph and the communication					
	plan at paragraph training and testin	, and the communication n (c) of this section. The ng program must be dated at least every 2 years.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/29/2021 155359 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7519 WINCHESTER RD MAJESTIC CARE OF FORT WAYNE FORT WAYNE. IN 46819 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and Event ID: FU8D21 Facility ID: 000250 Page 22 of 55 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

12/16/2021

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	î î	JILDING		r í	LETED
	or conduction	155359	B. W				9/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	ĒR			VINCHESTER RD		
MAJEST	IC CARE OF FOR	TWAYNE		FORT	WAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		am must be evaluated and					
	updated at every						
		eview and interview, the facility	E 0	036	What corrective action(s) will	I	12/10/202
		nergency preparedness policies			be accomplished for those		
	•	clude information for safe			residents found to have been	n	
	evacuation from the	ne LTC facility, which includes			affected by the deficient		
	consideration of ca	are and treatment needs of			practice;		
	evacuees; staff res			Emergency preparedness pol	icies		
		vacuation location(s); and			and procedures were updated	l to	
	primary and altern			include information in accorda	ince		
	with external sour	ces of assistance in accordance			with 42 CFR 483.73 (b) (3).		
	with 42 CFR 483.	73(b) (3). This deficient practice			How other residents having	the	
	could affect all oc	cupants.			potential to be affected by th	e	
					same deficient practice will I		
	Findings include:				identified and what corrective		
					action(s) will be taken;		
	Based on records a	Based on records review with the Administrator			All residents that reside in the		
	and the Maintenan			facility have the potential to be	Э		
	a.m., the provided			affected by the deficient pract	ice.		
	training and testin	g program. Based on interview			The Executive Director was		
	at the time of reco	rd review, the Administrator			educated on where to locate t	he	
	stated the facility t			written training and testing po	licy		
	documentation con			and procedure by the Regiona	-		
					Vice President of Operations		
	The finding was re	The finding was reviewed with the Administrator			12/10/21. These documents	were	
	and Maintenance	Director at the exit conference.			added to the Emergency		
					Operations Manual on 12/10/2	21.	
					What measures will be put in	nto	
					place and what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur;		
					The Emergency Operations P	lan	
					will be reviewed annually at a		
					minimum to ensure all require	d	
					policies, procedures and		
					documentation are present.		
					How the corrective action(s)		
					will be monitored to ensure		
					deficient practice will not		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	, <i>,</i>	UILDING	DNSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE			7519 W	ADDRESS, CITY, STATE, ZIP CO /INCHESTER RD WAYNE, IN 46819	D		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
					recur, i.e., what quality assurance program will into place; The training, testing and orientation program will evaluated and updated a minimum of annually . A updates will be brought t monthly QAPI meeting a education will be provide staff.	d be at a Any to the and		
E 0041 SS=F Bldg	§482.15(e) Cond (e) Emergency a The hospital mus standby power sy emergency plan this section and i	d LTC Emergency Power ition for Participation: nd standby power systems. t implement emergency and ystems based on the set forth in paragraph (a) of n the policies and set forth in paragraphs (b)(1)						
	The [LTC facility implement emerg systems based o	.625(e) nd standby power systems. and the CAH] must jency and standby power n the emergency plan set n (a) of this section.						
	Emergency gene generator must b the location requi Care Facilities Co Interim Amendme 12-4, TIA 12-5, a Code (NFPA 101 Amendments TIA	83.73(e)(1), §485.625(e)(1) rator location. The e located in accordance with rements found in the Health ode (NFPA 99 and Tentative ents TIA 12-2, TIA 12-3, TIA nd TIA 12-6), Life Safety and Tentative Interim A 12-1, TIA 12-2, TIA 12-3, nd NFPA 110, when a new						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(Y2) N	MULTIPLE CC	(Y3) D	(X3) DATE SURVEY	
			ì í		N31K0C110N	` ´	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING			COMPLETED	
		155359	B. V	VING		- 11	/29/2021
	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CC	D	
NAME OF	I KO VIDEK OK SOI I EIEI	Υ.		7519 W	INCHESTER RD		
MAJES	TIC CARE OF FORT	WAYNE		FORT V	VAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE	COMPLETI
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	structure is built o	r when an existing					
	structure or buildi	ng is renovated.					
	=	3.73(e)(2), §485.625(e)(2)					
		ator inspection and testing.					
		H and LTC facility] must hergency power system					
		and [maintenance]					
		nd in the Health Care					
		FPA 110, and Life Safety					
	Code.	······					
	482 15(e)(3) 848	3.73(e)(3), §485.625(e)(3)					
		ator fuel. [Hospitals, CAHs					
		that maintain an onsite fuel					
		mergency generators must					
		ow it will keep emergency					
		perational during the					
	emergency, unles	s it evacuates.					
	*[For hospitals at	§482.15(h), LTC at					
	§483.73(g), and C	CAHs §485.625(g):]					
	The standards inc	corporated by reference in					
	this section are a	pproved for incorporation by					
		Director of the Office of the					
		in accordance with 5 U.S.C.					
		R part 51. You may obtain					
		the sources listed below.					
		a copy at the CMS					
		urce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
	· ·	mation on the availability of ARA, call 202-741-6030, or					
	go to:	10, 0ai 202-7 - 1-0000, 0i					
	0	es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
	document in the F	-					

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/29/2021
	NAME OF PROVIDER OR SUPPLIER		7519	T ADDRESS, CITY, STATE, ZIP COI WINCHESTER RD T WAYNE, IN 46819)
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Batterymarch Pa Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Hea 2012 edition, issu (ii) Technical inte NFPA 99, issued (iii) TIA 12-3 to N 2012. (iv) TIA 12-4 to N 2013. (v) TIA 12-5 to N 2013. (vi) TIA 12-5 to N 2013. (vi) TIA 12-6 to N 2014. (vii) NFPA 101, L edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to N 30, 2012. (x) TIA 12-3 to N 22, 2013. (xi) TIA 12-4 to N 22, 2013. (xii) NFPA 110, S Standby Power S including TIAs to 2009. Based on observat failed to implement requirements found Code, NFPA 110, accordance with 42	Protection Association, 1 rk, 9, www.nfpa.org, Ith Care Facilities Code, and August 11, 2011. rim amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, ife Safety Code, 2012	E 0041	What corrective action(be accomplished for the residents found to have affected by the deficien practice; The generator was inspe repaired on 12/10/21 an found to power the emer- lighting required by LSC	bse been t ected and d was gency

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	r í	ILDING	DNSTRUCTION	COME	e survey pleted 9/2021
	PROVIDER OR SUPPLIE			7519 W	ADDRESS, CITY, STATE, ZIP COD /INCHESTER RD WAYNE, IN 46819		
MAJEST (X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O Based on observat Director on 11/29/ systems were not p not power the eme and NFPA 110. B record review, the generator was not The finding was re	T WAYNE STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> ion with the Maintenance 21 at 12:41 p.m., the generator properly functioning and would rgency lighting required by LSC ased on interview at the time of Maintenance Director state the properly working when tested. Eviewed with the Administrator Director at the exit conference.		ID PREFIX TAG	WAYNE, IN 46819 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) NFPA 110. How other residents havi potential to be affected by same deficient practice w identified and what corre- action(s) will be taken; All residents that reside in facility have the potential to affected by the deficient pr The Maintenance Director educated on ensuring the generator is functioning pr all times by the Executive Director/Designee on 12/1 What measures will be pu place and what systemic changes will be made to ensure that the deficient practice does not recur; Any issue with the generat powering the emergency li will be brought to the attenthe the Executive Director and addressed immediately thr the appropriate vendor. How the corrective actior will be monitored to ensure	ng the y the rill be ctive the o be actice. was operly at 0/21. ut into	(X5) COMPLETIC DATE
					deficient practice will not recur, i.e., what quality assurance program will b into place; The generator will be inspe weekly and test run for 30 monthly. The Maintenance Director will ensure all eme lighting is powered at that This will be documented in TELS system and verified Executive Director during t monthly QAPI meeting.	ected minutes ergency time. n the by the	

PRINTED:	12/16/2021
FORM APP	ROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 11/29/2021 155359 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7519 WINCHESTER RD MAJESTIC CARE OF FORT WAYNE FORT WAYNE, IN 46819 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0000 Bldg. 01 A Life Safety Code Recertification and State K 0000 Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/29/21 Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980 At this Life Safety Code survey, Majestic Care of Fort Wayne was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility 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 corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 66 and had a census of 60 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facilities services were sprinklered with the exception of a detached wood shed used for storage of maintenance supplies Quality Review completed on 11/30/21 Event ID: FU8D21 Facility ID: 000250 Page 28 of 55 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	r í	ILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE			7519 V	ADDRESS, CITY, STATE, ZIP COD VINCHESTER RD WAYNE, IN 46819	-	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	discharges, exit I in accordance wi of egress is conti all obstructions to emergency, unle through 18/19.2. 18.2.1, 19.2.1, 7. Based on observat failed to ensure 1 of were continuously obstructions. This residents in the east Findings include: Based on an obser facility with the M Between 10:00 a.m resident hall there supplies protrudin feet. Based on an i observations, the M there were wooder egress in the east H The finding was re	- General vays, corridors, exit ocations, and accesses are th Chapter 7, and the means nuously maintained free of o full use in case of ss modified by 18/19.2.2 11. 1.10.1 ion and interview, the facility of 4 corridor means of egresses maintained free of deficient practice affects 25 st hall. vation during a tour of the aintenance Director on 11/29/21 n. and 2:00 p.m., in the east were three wooden pallets of g into the corridor about three interview at the time of Maintenance Director agreed a pallets obstructing the pass of	K 02	211	What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice; On 12/10/21 the Maintenance Director/designee moved the pallets out of the east resider hall. How other residents having potential to be affected by t same deficient practice will identified and what correcti action(s) will be taken; Resident's that reside in the facility have the potential to b affected. The Executive Director/desig rounded in all areas of the fa on 12/8/21 to ensure that the were no items obstructing the pass of egress in the facility. What measures will be put if place and what systemic changes will be made to ensure that the deficient practice does not recur;	e 3 nts the he be ve nee cility re	12/10/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUIL		DNSTRUCTION	r í	E SURVEY PLETED
	of conduction	155359	B. WINC		<u>01</u>		9/2021
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	-	
MAJEST	IC CARE OF FOR	TWAYNE			WAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX FAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION DATE
					All staff were educated on the need to keep all items out o		
					means of egress by the Exe		
					Director/Designee on 12/10/		
					Majestic Rounds Ambassad		
					will round daily in order to en	nsure	
					compliance.		
					How the corrective action(will be monitored to ensure	•	
					deficient practice will not	ethe	
					recur, i.e., what quality		
					assurance program will be	put	
					into place;		
					QAPI tool Majestic Rounds	will be	
					completed weekly X 4 week		
					bi-monthly X 2 and monthly	X 4	
					months by Executive		
					Director/Designee If 100% threshold is not achieved an	action	
					plan will be developed. This		
					information will be presented		
					the QAPI committee during		
					monthly meeting.		
0222	NFPA 101						
SS=F	Egress Doors						
Bldg. 01	Egress Doors						
		ed means of egress shall not					
		a latch or a lock that					
		of a tool or key from the					
	-	ss using one of the following					
	special locking a	S OR SECURITY THREAT					
		S SIX SEGURITI THREAT					
		cking arrangements for the					
		eeds of the patient are					
	-	cking device shall be					
		h door and provisions shall					
		apid removal of occupants					
	by: remote contro	ol of locks; keying of all					

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/29/2021		
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP COD			
MAJESTIC CARE OF FORT WAYNE				WAYNE, IN 46819			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETIO	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	other such reliations staff at all times. 18.2.2.2.5.1, 18. 19.2.2.6 SPECIAL NEED ARRANGEMEN Where special loss afety needs of the Clinical or Se are being met. In electrical locks the release upon loss building is protect automatic sprink space is protected detection system at an attended los space); and both systems are arration. 18.2.2.2.5.2, 19. DELAYED-EGR ARRANGEMEN Approved, listed systems installed 7.2.1.6.1 shall but assemblies serv contents in build an approved, su detection system automatic sprink 18.2.2.2.4, 19.2. ACCESS-CONT LOCKING ARRA Access-Controllo installed in acco be permitted. 18.2.2.2.4, 19.2.	2.2.2.6, 19.2.2.5.1, S LOCKING TS ocking arrangements for the the patient are used, all of ecurity Locking requirements in addition, the locks must be hat fail safely so as to is of power to the device; the cted by a supervised ler system and the locked ed by a complete smoke in (or is constantly monitored ocation within the locked in the sprinkler and detection anged to unlock the doors 2.2.2.5.2, TIA 12-4 ESS LOCKING TS delayed-egress locking d in accordance with e permitted on door ing low and ordinary hazard ings protected throughout by pervised automatic fire in or an approved, supervised ler system. 2.2.4 ROLLED EGRESS ANGEMENTS ed Egress Door assemblies rdance with 7.2.1.6.2 shall					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/29/2021 155359 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7519 WINCHESTER RD MAJESTIC CARE OF FORT WAYNE FORT WAYNE. IN 46819 (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 LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility K 0222 What corrective action(s) will 12/10/2021 failed to ensure the means of egress through 5 of be accomplished for those 5 exits were readily accessible for residents residents found to have been without a clinical diagnosis requiring specialized affected by the deficient security measures. Doors within a required means practice; of egress shall not be equipped with a latch or On 12/10/21 the Maintenance lock that requires the use of a tool or key from the Director/designee placed all of the egress side unless otherwise permitted by LSC codes near the keypads to ensure 19.2.2.2.4. Door-locking arrangements shall be means of egress. permitted in accordance with 19.2.2.2.5.2. This How other residents having the deficient practice could affect all residents. potential to be affected by the same deficient practice will be Findings include: identified and what corrective action(s) will be taken; Based on an observation during a tour of the Resident's that reside in the facility with the Maintenance Director on 11/29/21 facility have the potential to be between 11:00 a.m. and 1:13 p.m., all exit doors affected. were magnetically locked, and could be opened by The Executive Director/designee entering a four-digit code on the access control audited all doors requiring a pad, but the four digit codes were not posted by means of egress to ensure that the keypads. This condition could delay someone the codes were posted near the from exiting the building during an emergency. keypads to ensure means of Based on interview at the time of observation, the egress. Maintenance Director agreed codes were not What measures will be put into posted at the keypads. place and what systemic changes will be made to The finding was reviewed with the Administrator ensure that the deficient and the Maintenance Director during the exit practice does not recur; conference. All staff were educated on the need to keep the posted codes 3.1-19(b) near the keypads on doors FU8D21 Facility ID: 000250

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Event ID:

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12/16/2021

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	, í	ILDING	ONSTRUCTION 01	COMI	x3) date survey completed 11/29/2021	
	PROVIDER OR SUPPLIE		-	7519 V	ADDRESS, CITY, STATE, ZIP COD VINCHESTER RD WAYNE, IN 46819	-		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
					requiring means of egress ar location of those codes by th Executive Director/Designee 12/10/21. Majestic Rounds Ambassado will round daily in order to en compliance. How the corrective action(s will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; QAPI tool Majestic Rounds w completed weekly X 4 weeks bi-monthly X 2 and monthly X months by Executive Director/Designee If 100% threshold is not achieved an plan will be developed. This information will be presented the QAPI committee during the monthly meeting.	e on ors isure is put vill be s, K 4 action		
K 0232 SS=E Bldg. 01	unobstructed) se at least 4 feet and convenient remo on stretchers, ex 19.2.3.4, exception 19.2.3.4, 19.2.3.4 Based on observat failed to meet the of corridors or met an 19.2.3.4(5) states of	Ramp Width es or corridors (clear or rving as exit access shall be d maintained to provide the val of nonambulatory patients cept as modified by ons 1-5.	K 02	232	What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice;		12/10/202	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLE	
		155359	B. WING	<u> </u>	11/29/2	
				ADDRESS STATE ZID COD		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
MAJEST	TIC CARE OF FOR	TWAYNE		WAYNE, IN 46819		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	-	DATE
	shall be permitted	for fixed furniture, provided that		On 12/10/21 the Maintenance		
	all of the following	g conditions are met:		Director/designee moved the 2		
	(a) the fixed furnit	ure is securely attached to the		chairs to another location.		
	floor or to the wall	-				
	(b) the fixed furnit	ure does not reduce the clear		How other residents having th	e	
		dor width to less than six feet,		potential to be affected by the		
	except as permitte			same deficient practice will be		
		ure is located only on one side		identified and what corrective		
	of the corridor.			action(s) will be taken;		
		ure is grouped such that each		Resident's that reside in the		
		exceed an area of 50 square		facility have the potential to be		
	feet.	enceed an area of 50 square		affected.		
		ure groupings addressed in		The Executive Director/designe	<u> </u>	
				rounded in all areas of the facili		
	19.2.3.4(5) (d) are separated from each other by distance of at least 10 feet.			on $12/8/21$ to ensure that there	Ly .	
		ure is located so as to not		were no items obstructing the		
	. ,	building service and fire				
	protection equipme	-		pass of egress in the facility.		
		ghout the smoke compartment			_	
				What measures will be put into	0	
		electrically supervised letection system in accordance		place and what systemic		
				changes will be made to		
		fixed furniture spaces are		ensure that the deficient		
		ed to allow direct supervision		practice does not recur;		
		f from a nurse's station or similar		All staff were educated on the		
	space.			need to keep all items out of the		
		partment is protected		means of egress unless affixed	το	
		pproved, supervised automatic		the floor or the wall by the		
		accordance with 19.3.5.8		Executive Director/Designee on	1	
	-	tice could affect 5 residents in		12/10/21.		
	front hall.			Majestic Rounds Ambassadors		
				will round daily in order to ensur	re	
	Findings include:		compliance.			
				How the corrective action(s)		
		vation during a tour of the		will be monitored to ensure th	е	
	· · ·	aintenance Director on 11/29/21		deficient practice will not		
		chairs in the main entrance		recur, i.e., what quality		
		about two feet into the corridor		assurance program will be put	t	
		ed to the floor or to the wall		into place;		
		d on interview at the time of the		QAPI tool Majestic Rounds will	be	
	observations, the M	Maintenance Director agreed		completed weekly X 4 weeks,		

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Event ID:

FU8D21 Facility ID: 000250

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLI A. BUILDING B. WING	e construction g <u>01</u>	COM	e survey pleted 9/2021
NAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COI 9 WINCHESTER RD)	
MAJEST	IC CARE OF FOR	TWAYNE	FOR	RT WAYNE, IN 46819		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION
TAG	the chairs were no or to the wall when	R LSC IDENTIFYING INFORMATION t securely attached to the floor n tested.	TAG	bi-monthly X 2 and mont months by Executive Director/Designee If 100 threshold is not achieved	%	DATE
		ce Director during the exit		plan will be developed. information will be prese the QAPI committee duri monthly meeting.	This nted to	
< 0324 SS=E Bldg. 01	accordance with Ventilation Contr Commercial Coo * residential cook appliances such toasters) are use cooking in accord 19.3.2.5.2 * cooking facilitie smoke compartm patients comply 18.3.2.5.3, 19.3.2 * cooking facilitie with 30 or fewer conditions under Cooking facilities	s ent is protected in NFPA 96, Standard for ol and Fire Protection of king Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited dance with 18.3.2.5.2, s open to the corridor in tents with 30 or fewer with the conditions under				
	enclosed as haza be open to the co 18.3.2.5.1 throug through 19.3.2.5. Based on observat failed to ensure sta the UL 300 hood s 96, 11.1.4 states in operating the fire of	ardous areas, but shall not	d to be shall not 3.2.5.1 2 the facility in the use of chens. NFPA ually m shall be K 0324 What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice; On 12/10/21 the Executive		esidents ted by the ve	12/10/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	COME	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7519 V	ADDRESS, CITY, STATE, ZIP COD			
IVIAJES I		TWATNE	FORT	WAYNE, IN 46819		-	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	'ION D BE OPRIATE	(X5) COMPLETIC DATE	
TAG	reviewed with emp deficient practice of and 25 residents in Findings include: Based on an obser facility with the M at 11:41 p.m., the J 300 hood system a with posted instruct Cook was asked he suppression system underneath the hoo not know how to a or the location of p suppression system acknowledged the staff will need to b procedures for exti cooking equipmen The finding was ref	bloyees by management. This could affect staff in the kitchen a the dining room. vation during a tour of the a intenance Director on 11/29/21 kitchen was provided with a UL nd a K-class fire extinguisher ctions. Based on interview, the bow to activate the hood n if there was a grease fire od. The Cook stated she did ctivate the suppression system bull station to activate the n. The Maintenance Director Cook's response and stated te trained on the proper inguishing a grease fire on the		 kitchen staff as to how to UL 300 hood system and fire extinguisher. How other residents hav potential to be affected to same deficient practice will identified and what correct action(s) will be taken; Resident's that reside in the facility have the potential of affected. The Executive Director/det rounded in all areas of the on 12/10/21 to ensure that were no further items that kitchen staff were unawar to utilize in case of an em What measures will be p place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were educated or properly utilize the UL 300 system and K-class fire extinguisher by the Execut Director/Designee on 12/7 Majestic Rounds Ambass will round daily in order to compliance. How the corrective action will be monitored to ensure deficient practice will no recur, i.e., what quality assurance program will be into place; QAPI tool Majestic Rounds 	K-class ing the by the will be ective the to be esignee e kitchen t there the e of how ergency. ut into how to hood tive (0/21. adors ensure n(s) ure the t be put	DATE	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION (X	(3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155359	B. WING		11/29/2021
NAME OF I	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP COD	
				VINCHESTER RD	
MAJEST	IC CARE OF FOR	Γ WAYNE	FORT	WAYNE, IN 46819	
(X4) ID		MARY 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 APPROPRIATE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				bi-monthly X 2 and monthly X 4	
				months by Executive	
				Director/Designee If 100%	
				threshold is not achieved an acti	ion
				plan will be developed. This	
				information will be presented to	
				the QAPI committee during the	
				monthly meeting.	
0346	NFPA 101				
S=C	-	n - Out of Service			
ldg. 01	Fire Alarm - Out				
5		re alarm system is out of			
		than 4 hours in a 24-hour			
		rity having jurisdiction shall			
		ne building shall be			
		approved fire watch shall be			
		arties left unprotected by the			
		e fire alarm system has			
	been returned to	-			
	9.6.1.6				
		view and interview, the facility	K 0346	What corrective action(s) will be	12/10/202
		complete 1 of 1 written policy	K 05 10	accomplished for those resident	
	-	of residents indicating		found to have been affected by	
	-	blowed in the event the fire		deficient practice;	
	•	b be placed out of service for		On 12/10/21 the Maintenance	
		in a twenty four hour period in		Director/designee ensured that t	he
		SC, Section 9.6.1.6. This		fire watch plan in the EPP	
		ffects all occupants.		included contacting the Indiana	
		•		Department of Health via the ID	он
	Findings include:			Gateway Link at	
	-			https://gateway.isdh.in.gov as th	e
	Based on records r	eview with the Maintenance		primary method or by the	
	Director and Admi	nistrator on 11/29/21 at 9:35		secondary method when the IDC	ОН
	a.m., the fire watch	plan failed to include		Gateway is nonoperational by	
		ana Department of Health via		completing the Incident Reportin	ng
	the IDOH Gateway	-		form and e-mailing it to	-
		h.in.gov as the primary method		incidents@isdh.in.gov.	
				How other residents having the	
	or by the secondar	y method when the IDOH		Thow other residents having the	-

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		· · · · · · · · · · · · · · · · · · ·	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155359	A. BUILDING B. WING	01	COMPLETED 11/29/2021
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD	
MAJEST	TIC CARE OF FOR	T WAYNE		WINCHESTER RD WAYNE, IN 46819	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	COMPLETIC DATE
	Incident Reporting	g form and e-mailing it to		same deficient practice will be	9
	incidents@isdh.in	.gov. Based on interview during		identified and what corrective	
		the Maintenance Director		action(s) will be taken;	
	-	fire watch documentation		Resident's that reside in the	
	·	contact the IDOH but not via		facility have the potential to be	
		y link or at the e-mail address		affected.	
	listed above.			The Executive Director/designe	
	TT1 · (* 1·	• • • • • • • • • • • • • • • • • • • •		audited the EPP on 12/10/21 in	
	Ũ	eviewed with the Administrator		order to ensure that the fire wa	ich
	conference.	Director during the exit		plan included contacting the	ia
	conterence.			Indiana Department of Health v	la
	3.1-19(b)			the IDOH Gateway Link at <u>https://gateway.isdh.in.gov</u> as t	he
	5.1-17(0)			primary method or by the	
				secondary method when the ID	ОН
				Gateway is nonoperational by	
				completing the Incident Reporti	ng
				form and e-mailing it to	0
				incidents@isdh.in.gov.	
				What measures will be put int	o
				place and what systemic	
				changes will be made to	
				ensure that the deficient	
				practice does not recur;	
				All staff were educated on the	
				need to contact the Indiana	
				Department of Health via the IE	ЮН
				Gateway Link at	ha
				https://gateway.isdh.in.gov as t primary method or by the	ne
				secondary method when the ID	ОН
				Gateway is nonoperational by	
				completing the Incident Reporti	na
				form and e-mailing it to	
				incidents@isdh.in.gov in the ca	se
				of fire watch by the Executive	
				Director/Designee on 12/10/21.	
				This will be audited weekly by t	
				ED/designee in order to ensure	
				compliance.	
	1			1	

	R MEDICARE & MEDI					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTI A. BUILD B. WING	ple construction ing <u>01</u>	COM	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7:	REET ADDRESS, CITY, STATE, ZIP CO 519 WINCHESTER RD ORT WAYNE, IN 46819	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE	
				How the corrective act will be monitored to er deficient practice will a recur, i.e., what quality assurance program wi into place; QAPI tool EPP will be c weekly X 4 weeks, bi-m and monthly X 4 month Executive Director/Desi 100% threshold is not a action plan will be deve information will be prese the QAPI committee du monthly meeting.	I be put ompleted onthly X 2 s by gnee If chieved an loped. This ented to		
K 0354 SS=C Bldg. 01	extent and durati been determined are inspected and recommendation management or of and the fire depa having jurisdictio the sprinkler syst than 10 hours in building or portio evacuated or an provided until the returned to service 18.3.5.1, 19.3.5. ² Based on record re failed to provide 1 the event the autor placed out-of-service 24-hour period in a	- Out of Service ler system is impaired, the on of the impairment has , areas or buildings involved d risks are determined, s are submitted to designated representative, rtment and other authorities in have been notified. Where em is out of service for more a 24-hour period, the n of the building affected are approved fire watch is sprinkler system has been	K 0354	What corrective action be accomplished for the residents found to have affected by the deficient practice; On 12/10/21 the Mainter	nose ve been nt	12/10/202	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>01</u>	COMPL	(X3) DATE SURVEY COMPLETED 11/29/2021	
NAME OF PROVIDER OR SUPPLI		7519	T ADDRESS, CITY, STATE, ZIP COD WINCHESTER RD			
MAJESTIC CARE OF FOR	I WAYNE	FORT	WAYNE, IN 46819			
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETIC DATE	
procedures completethe Standard for theMaintenance of WSystems. NFPA 2procedures that thefollow. A.15.5.2 (consist of trainedpatrol the affectedextinguishers andthe fire departmentconsider. During theshould not only besure that the otherbuilding such as eare available anddeficient practicefacility.Findings include:Based on recordsDirector and Adma.m., the fire watchcontacting the Indthe IDOH Gatewayhttps://gateway.isor by the secondaGateway is nonopIncident Reportinincidents@isdh.inthe IDOH Gatewaatknowledged theprovided stated tothe IDOH Gatewalisted above.This finding was the	DR LSC IDENTIFYING INFORMATION y with NFPA 25, 2011 Edition, ne Inspection, Testing and Vater-Based Fire Protection 25, 15.5.2 requires nine e impairment coordinator shall 4) (b) states a fire watch should personnel who continuously a area. Ready access to fire the ability to promptly notify at are important items to he patrol of the area, the person e looking for fire, but making fire protection features of the gress routes and alarm systems functioning properly. This could affect all occupants in the review with the Maintenance inistrator on 11/29/21 at 9:35 h plan failed to include iana Department of Health via yy link at th.in.gov as the primary method ry method when the IDOH erational by completing the g form and e-mailing it to .gov. Based on interview during the Maintenance Director fire watch documentation contact the IDOH but not via yy link or at the e-mail address	TAG	Director/designee ensured fire watch plan in the EPP included the policy as to the procedures of for when the sprinkler system is down for than 10 hours and the need contact the Indiana Departm Health via the IDOH Gatew at https://gateway.isdh.in.go the primary method or by the secondary method when the Gateway is nonoperational completing the Incident Rep form and e-mailing it to incidents@isdh.in.gov. How other residents havin potential to be affected by same deficient practice wi identified and what correct action(s) will be taken; Resident's that reside in the facility have the potential to affected. The Executive Director/desi audited the EPP on 12/10/2 order to ensure that the fire plan included EPP included policy as to the procedures when the sprinkler system i for more than 10 hours and contacting the Indiana Depa of Health via the IDOH Gate Link at https://gateway.isdh as the primary method or by secondary method when the Gateway is nonoperational completing the Incident Rep form and e-mailing it to	that the e r more to nent of ay Link <u>ov</u> as le IDOH by porting g the the II be tive be dignee 11 in watch the for s down artment eway <u>.in.gov</u> y the e IDOH by	DATE	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED		
		155359	B. WING		11/29/	2021	
	PROVIDER OR SUPPLIE		7519 V	ADDRESS, CITY, STATE, ZIP COD VINCHESTER RD WAYNE, IN 46819			
	T		I				
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFLICIENCY)	ΤE	(X5) COMPLETION	
TAG	REGULATORY 0 3.1-19(b)	R LSC IDENTIFYING INFORMATION	TAG	perferences place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff were educated on the need for the EPP to included policy as to the procedures for when the sprinkler system is of for more than 10 hours and to contact the Indiana Departme Health via the IDOH Gateway at <u>https://gateway.isdh.in.gov</u> the primary method or by the secondary method when the II Gateway is nonoperational by completing the Incident Repor form and e-mailing it to incidents@isdh.in.gov in the co of fire watch by the Executive Director/Designee on 12/10/2° This will be audited weekly by ED/designee in order to ensure compliance. How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p into place; QAPI tool EPP will be complet weekly X 4 weeks, bi-monthly and monthly X 4 months by Executive Director/Designee I 100% threshold is not achieved action plan will be presented to the QAPI committee during the	the r down nt of Link as DOH ting case 1. the re the ted X 2 f ed an This to	DATE	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	LE CONSTRUCTION	· · ·	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155359	A. BUILDIN B. WING	G <u>01</u>		COMPLETED 11/29/2021	
NAME OF	PROVIDER OR SUPPLIE	R	STR 75				
MAJEST	IC CARE OF FOR	TWAYNE		9 WINCHESTE RT WAYNE, IN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		IDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REF	RECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAC	ì	DEFICIENCY)	DATE	
0355	NFPA 101						
SS=E	Portable Fire Ext	-					
8ldg. 01	Portable Fire Ext	0					
		nguishers are selected,					
		ed, and maintained in					
		NFPA 10, Standard for					
	Portable Fire Ext	0					
	18.3.5.12, 19.3.5		17 02 55			12/10/2021	
		rvation and interview, the	K 0355		ective action(s) will be	12/10/2021	
		isure 1 of 15 portable fire			shed for those residents		
	-	installed in accordance with			nave been affected by the	; ;	
		d for Portable Fire Extinguishers,		deficient p			
		ion 6.1.3.4 states portable fire r than wheeled extinguishers			21 the Executive		
	-	sing any of the following			esignee ensured that the		
		y on a hanger intended for the			extinguisher in the		
		In the bracket supplied by the			ation was properly		
		facture. (3) In a listed bracket			o the wall in the dining that all 15 of the		
	-	purpose. (3) In a cabinet or wall			ire extinguishers were		
		ent practice could affect 20			ntenance within a years		
		noke compartment.		time.	illenance within a years		
		loke compartment.			r residents having the		
	Findings include:				to be affected by the		
	i manigo merade.			-	icient practice will be		
	Based on an obser	vation during a tour of the			and what corrective		
		aintenance Director on 11/29/21			will be taken;		
		ABC portable fire extinguisher			s that reside in the		
	-	elf unsecured in the nurse's			ve the potential to be		
	-	interview at the time of		affected.	1		
		aintenance Director stated the			lesignees completed		
		rom the dining room and need			Rounds in all areas on		
	to be remounted.	-		-	to ensure that all		
					ire extinguishers were		
	#2. Based on obser	rvation and interview, the			properly to the wall and		
	facility failed to en	sure 1 of 15 portable fire			received their annual		
	extinguishers was	given maintenance at periods		-	n within the past year.		
	not more than one	year apart. NFPA 10, the			asures will be put into		
	Standard for Porta	ble Fire Extinguishers, at			what systemic		
	Section 7.3.1.1.1 r	equires that fire extinguishers		-	will be made to		
	abolt he autored	to maintenance at intervals of	1	-	at the deficient		

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	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 11/29/2021		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 7519 WINCHESTER RD FORT WAYNE, IN 46819				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR 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		
	not more than 1 yet test, or when speci inspection or elect 3.3.15 defines extii thorough examinar is intended to give extinguisher will or and to determine is will prevent its op- replacement is nec- testing or internal Section 7.3.3 state have a tag or label indicates the mont performed, identific performed, identific performing the wo 2 residents in the b Findings include: Based on an obser facility with the M at 12:02 p.m., the is therapy gym had a July 2020 while al building had an im- Based on interview the Maintenance II the extinguisher in during the annual is	ear, at the time of hydrostatic ifically indicated by an ronic notification. Section nguisher maintenance as a tion of the fire extinguisher that maximum assurance that a fire operate effectively and safely f physical damage or condition eration, if any repair or vessary, and if hydrostatic maintenance is required. s each fire extinguisher shall securely attached that h and year the maintenance was ies the person performing the est he name of the agency ork. This deficient practice could beauty shop. vation during a tour of the laintenance Director on 11/29/21 tag on the fire extinguisher in the mannual inspection date of 1 other fire extinguishers in the spection date of July 2021. v at the times of observation, Director stated it is most like that a beauty shop was missed		practice does not recur; All staff were educated on how ensure that the portable fire extinguishers were properly secured to the wall and where audit to ensure that they were serviced in the past year by th Executive Director/Designee of 12/10/21. Majestic Rounds Ambassador will round daily in order to ensi- compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be p- into place; QAPI tool Majestic Rounds will completed weekly X 4 weeks, bi-monthly X 2 and monthly X months by Executive Director/Designee If 100% threshold is not achieved an a plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	v to e on s ure tu		
0521 SS=E	NFPA 101 HVAC						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE	R		street 7519 V	ADDRESS, CITY, STATE, ZIP COD VINCHESTER RD WAYNE, IN 46819		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Bldg. 01	comply with 9.2 a accordance with specifications. 18.5.2.1, 19.5.2.7 Based on record refailed to ensure 4 d were repaired after NFPA 90A. LSC and air conditionin equipment shall be Standard for the In and Ventilating Sy Edition, Section 5. maintained in accor for Fire Doors and NFPA 80, 2010 Ec damper shall be ter installation. Section for Fire Doors and NFPA 80, 2010 Ec damper shall be ter installation. Section for fire doors and NFPA 80, 2010 Ec damper shall be ter installation. Section for hospital 6 years. If the dam link, the link shall full closure and loo damper shall not b way. All inspection documented, indic damper, date of inside ficiencies discow have a space to ind deficiencies were co practice could affee compartments. Findings include: Based on records r and the Maintenan	on, and air conditioning shall and shall be installed in the manufacturer's 1, 9.2 view and interview, the facility of 79 fire dampers in the facility of 92.1 requires heating, ventilating g (HVAC) ductwork and related of in accordance with NFPA 90A, stallation of Air-Conditioning stems. NFPA 90A, 2012 4.8.1 states fire dampers shall be rdance with NFPA 80, Standard Other Opening Protectives. Bition, Section 19.4.1 states each sted and inspected 1 year after on 19.4.1.1 states the test and cy shall then be every 4 years is where the frequency is every per is equipped with a fusible be removed for testing to ensure ck-in-place if so equipped. The e blocked from closure in any ons and testing shall be ating the location of the fire spection, name of inspector and vered. The documentation shall licate when and how the corrected. This deficient et 50 residents in three smoke	K 05	521	What corrective action(s) will accomplished for those reside found to have been affected I deficient practice; On 12/10/21 the Executive Director/designee ensured th 4 Fire Dampers were Inspect and in working order. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken; Resident's that reside in the facility have the potential to be affected. The Maintenance Director/designee inspected at dampers throughout the facilit 12/10/21 to ensure that they in working order. What measures will be put i place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director an Designee were educated on the need for all Fire Dampers to v and to have documented inspections once every 4 year the Executive Director/Design on 12/10/21. The Maintenance	ents by the at the ed the be ve e all fire ty on were nto d the work rs by	12/10/2021

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	onstruction <u>01</u>	· · ·	E SURVEY PLETED	
		155359	B. WING		11/2	9/2021	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 7519 WINCHESTER RD				
MAJEST	IC CARE OF FOR	ΓWAYNE	FORT	WAYNE, IN 46819			
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	replaced. No other to show if the four re-inspected. Base records review, the confirmed there we form that needed r documentation cour repairs were made. The finding was re	dampers needed repairs or documentation was provided dampers were fixed or d on interview at the time of Maintenance Director ere dampers on the inspection epair and stated there no other ild be found to show if the viewed with the Administrator Director at the exit conference.		Director/designee will au for compliance. How the corrective acti will be monitored to en deficient practice will n recur, i.e., what quality assurance program will into place; QAPI tool Preventative Maintenance will be com weekly X 4 weeks, bi-mo and monthly X 4 months Executive Director/Desig 100% threshold is not ac action plan will be develo information will be preset the QAPI committee dur monthly meeting.	on(s) sure the ot I be put npleted onthly X 2 by nee If chieved an oped. This nted to		
K 0741 SS=E Bldg. 01	 shall include not provisions: (1) Smoking shal ward, or compart liquids, combustil used or stored ar location, and suc signs that read N posted with the ir smoking. (2) In health care smoking is prohit prominently place secondary signs smoking shall no 	ions ons shall be adopted and less than the following I be prohibited in any room, ment where flammable ole gases, or oxygen is ad in any other hazardous h area shall be posted with O SMOKING or shall be aternational symbol for no occupancies where bited and signs are ed at all major entrances, with language that prohibits t be required. atients classified as not					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/29/2021 155359 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7519 WINCHESTER RD MAJESTIC CARE OF FORT WAYNE FORT WAYNE. IN 46819 (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 (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4. 19.7.4 Based on observation and interview; the facility K 0741 12/10/2021 What corrective action(s) will failed to ensure 1 of 2 smoking areas were be accomplished for those maintained by disposing cigarette butts in a metal residents found to have been or noncombustible container with self-closing affected by the deficient cover devices. This deficient practice could affect practice: staff and 20 residents in the courtyard. On 12/10/21 the Executive Director/designee ensured that the Findings include: smoking area was equipped with a self closing cigarette butt disposal Based on an observation during a tour of the container. facility with the Maintenance Director on 11/29/21 How other residents having the at 12:41 p.m., in the courtyard resident smoking potential to be affected by the area there were over 30 cigarette butts disposed same deficient practice will be on the ground in and around the smoking area. identified and what corrective Based on interview at the time of observation, the action(s) will be taken; Maintenance Director agree there were cigarette Resident's that reside in the butts on the ground in the resident smoking area. facility have the potential to be affected. This finding was reviewed with the Administrator The IDT/designees completed and Maintenance Director during the exit Majestic Rounds in all areas on conference. 12/10/21 to ensure that the self closing container was in place and 3.1-19(b) that there were no cigarette butts on the ground in the smoking area. What measures will be put into place and what systemic changes will be made to ensure that the deficient

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

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	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V 2) MU	LTIPLE CONS	TRUCTION	-	IB NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	· · ·	ILDING	<u>01</u>	x3) date survey completed 11/29/2021	
	PROVIDER OR SUPPLIE		-	7519 WIN	DRESS, CITY, STATE, ZIP COD CHESTER RD YNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
				ρ print the M w c H w d r a ii C c b n E th print the the the the the the the the the th	All staff were educated on how properly dispose of cigarette b in the residents smoking area the Executive Director/Designed on 12/10/21. Majestic Rounds Ambassador vill round daily in order to ensu- compliance. How the corrective action(s) vill be monitored to ensure to leficient practice will not ecur, i.e., what quality assurance program will be pro- nto place; DAPI tool Majestic Rounds will completed weekly X 4 weeks, bi-monthly X 2 and monthly X nonths by Executive Director/Designee If 100% hreshold is not achieved an a plan will be developed. This information will be presented to the QAPI committee during the nonthly meeting.	utts by ee s ure he I be 4 ction	
< 0911 SS=E Bldg. 01	Chapter 6 Electri that are not addr K-Tags, but are of along with the ap NFPA standard of on Form CMS-25 Chapter 6 (NFPA Based on observat failed to ensure 2 of	ns - Other RKS section any NFPA 99 cal Systems requirements essed by the provided deficient. This information, oplicable Life Safety Code or citation, should be included 567.	К 09	a	Vhat corrective action(s) will b accomplished for those reside ound to have been affected b	nts	12/10/202

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	.DING	01	COMP	LETED
		155359	B. WING	G		11/29/2021	
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R		7519 W	INCHESTER RD		
MAJEST	IC CARE OF FOR	TWAYNE		FORT	WAYNE, IN 46819		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	NFPA 99, Health	Care Facilities Code, 2012			deficient practice;		
	Edition, Section 6.			On 12/10/21 the Executive			
	shall be in accorda	nce with NFPA 70, National			Director/designee ensured that	at the	
	Electric Code. NF	PA 70, 2011 Edition, Article			bin and barrel in the laundry ro	oom	
	110.26 states acces	ss and working space shall be			were removed from blocking t	he	
	provided and main	tained about all electrical			electrical panels.		
	equipment to perm	it ready and safe operation and			How other residents having	the	
	maintenance of su	ch equipment. Working space			potential to be affected by th		
	for equipment oper			same deficient practice will b			
		equire examination, adjustment,			identified and what correctiv		
	-	tenance while energized shall			action(s) will be taken;	-	
	-	imensions of 110.26(A) (1), (2)			Resident's that reside in the		
		(1) states the depth of the			facility have the potential to be	2	
		he direction of live parts shall			affected.	, ,	
		at specified in Table 110.26(A)			The IDT/designees completed	1	
		mum clear distance is 3 feet.			Majestic Rounds in all areas o		
		es the width of the working			12/10/21 to ensure that there		
		e electrical equipment shall be				were	
	-	uipment or 762 mm (30 in.),			no items blocking electrical		
					panels.		
	-	er. In all cases, the workspace			What measures will be put in	ito	
	-	a 90-degree opening of			place and what systemic		
		r hinged panels. 110.26(A)(3)			changes will be made to		
	-	ce shall be clear and extend			ensure that the deficient		
	-	or, or platform to a height of			practice does not recur;		
		ight of the equipment,			All staff were educated on the		
	Ç.	er. Article 110.26(B) states the			importance of keeping items o		
		uired by this section shall not			obstruction of all electrical par	nels	
	-	e. This deficient practice could			by the Executive		
	30 residents in one	hall			Director/Designee on 12/10/2		
					Majestic Rounds Ambassador		
	Findings include:				will round daily in order to ens	ure	
					compliance.		
		vation during a tour of the			How the corrective action(s)		
		aintenance Director on 11/29/21			will be monitored to ensure t	the	
	at 10:48 a.m., two	equipment electrical panels in			deficient practice will not		
		were blocked from access and			recur, i.e., what quality		
	did not have a clea	r workspace due to a bin and			assurance program will be p	ut	
		nt of the panels. Based on			into place;		
		ne of the observations, the			QAPI tool Majestic Rounds wi	ll be	
		eed items were stored within the			completed weekly X 4 weeks,		

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155359	ì í	ILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE			7519 V	ADDRESS, CITY, STATE, ZIP COD /INCHESTER RD WAYNE, IN 46819		
(X4) ID	SUMMADY	STATEMENT OF DEFICIENCIE		ID	,		(X5)
PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	COMPLETION DATE
	The finding was re and the Maintenan conference. 3.1-19(b)	ront of the electrical panels. viewed with the Administrator ce Director during the exit			bi-monthly X 2 and monthly X 4 months by Executive Director/Designee If 100% threshold is not achieved an ac plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	tion	
K 0916 SS=F Bldg. 01	Electrical System System Alarm Ar A remote annunce powered is provid generating room observed by open annunciator is ha conditions of the centralized comp information syste for the alarm ann 6.4.1.1.17, 6.4.1. Based on record re failed ensure 1 of 1 annunciator panels power to indicate a generator in accord This deficient prace Findings include: Based on an obser- facility with the M at 12:11 p.m., the g showed there was a the status of the ge interview with the Generator Technic	iator that is storage battery led to operate outside of the in a location readily rating personnel. The rd-wired to indicate alarm emergency power source. A uter system (e.g., building m) is not to be substituted	K 09	916	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 11/29/21 the Executive Director/designee ensured that charger to the generator battery was replaced, leaving the generator's annunciator panel i working condition. On 12/10/2 ⁻ the Executive Director/designee ensured that the generator's annunciator panel was hard-win to normal power to indicate alar conditions. How other residents having th	the y n 1 e red rm	12/10/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· · ·	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155359	A. BUILDING B. WING	<u>01</u>	completed 11/29/2021	
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD		
MAJEST	IC CARE OF FOR	TWAYNE		WINCHESTER RD WAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	-	ing the battery dead, therefore		potential to be affected by the		
		nnunciator panel. When the		same deficient practice will be		
		ian was asked if the		identified and what corrective	Į.	
	-	was connected to normal		action(s) will be taken;		
	· ·	o; the annunciator panel is only		Resident's that reside in the		
		ttery from the generator. The		facility have the potential to be		
		ian did replace the charger and		affected.		
	battery leaving the condition.	annunciator panel in working		The Maintenance		
	condition.			Director/designee completed a		
	The finding was re	eviewed with the Administrator		load test on the generator on 12/10/21 to ensure that it is in		
	-	ce Director during the exit				
	conference.	ce Director during the exit		working order. What measures will be put int		
	conterence.			place and what systemic	0	
	3.1-19(b)			changes will be made to		
	5.1-19(0)			ensure that the deficient		
				practice does not recur;		
				The Maintenance Director and		
				Designee were educated on the	e	
				need to complete and documer		
				the load test weekly and to repo		
				any issues with the generator		
				immediately to the Executive		
				Director by the Executive		
				Director/Designee on 12/10/21		
				The Maintenance		
				Director/designee will audit wee	ekly	
				for compliance.		
				How the corrective action(s)		
				will be monitored to ensure th	ie	
				deficient practice will not		
				recur, i.e., what quality		
				assurance program will be pu	t	
				into place;		
				QAPI tool Preventative		
				Maintenance will be completed		
				weekly X 4 weeks, bi-monthly >	(2	
				and monthly thereafter by		
				Executive Director/Designee If	.	
				100% threshold is not achieved	lan	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155359	A. BUILDING <u>01</u> B. WING		COMPLETED 11/29/2021	
NAME OF 1	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP C	COD	
				9 WINCHESTER RD		
MAJEST	IC CARE OF FOR	TWAYNE	FOF	RT WAYNE, IN 46819		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX		HOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				action plan will be dev information will be pre- the QAPI committee d monthly meeting.	sented to	
C 0918	NFPA 101					
SS=F	-	is - Essential Electric Syste				1
Bldg. 01		is - Essential Electric				
	System Maintena	ance and Testing				
	-	r other alternate power				
		ciated equipment is capable				
		ice within 10 seconds. If the				
		on is not met during the				
		rocess shall be provided to this capability for the life				
	-	l branches. Maintenance				
	-	generator and transfer				
	-	formed in accordance with				
		re inspected weekly,				
		load 30 minutes 12 times a				
	year in 20-40 day	intervals, and exercised				
	once every 36 m	onths for 4 continuous hours.				
	Scheduled test u	nder load conditions include				
		ated cold start and				
		nual transfer of all EES				
		onducted by competent				
		enance and testing of stored				
		urces (Type 3 EES) are in NFPA 111. Main and feeder				
		re inspected annually, and a				1
		dically exercising the				1
		stablished according to				
		uirements. Written records				
		and testing are maintained				
		able. EES electrical panels				
	and circuits are n	narked, readily identifiable,				
		n normal power circuits.				
		ossibility of damage of the r source is a design				

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		01	COMP		
	S. CONTECTION	155359	B. W		<u></u>		29/2021	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE	R			/INCHESTER RD			
MAJEST	IC CARE OF FOR	TWAYNE			WAYNE, IN 46819			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E	COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		new installations.						
		4 (NFPA 99), NFPA 110,						
	NFPA 111, 700.1							
	Based on record review and interview, the facility		K 0	918	What corrective action(s)		12/10/202	
		of 1 emergency generators were			be accomplished for those			
		ed and in working condition.			residents found to have be	en		
	This deficient prac	tice could affect all occupants.			affected by the deficient practice;			
	Findings include:				On 11/29/21 the Executive			
	Based on an obser			Director/designee ensured t charger to the generator bat				
		Based on an observation during a tour of the facility with the Maintenance Director on 11/29/21			was replaced, leaving the	liei y		
	at 12:11 p.m., the generator annunciator panel showed there was no power to the panel leaving the status of the generator unknown. Upon inspection of the generator, the generator would not start due to a dead battery. Based on interview with the Maintenance Director and Generator Technician from the facility's contracted generator service provider at 1:10 p.m., the				generator's annunciator par	uel in		
					working condition. On 12/10			
					the Executive Director/desig			
					ensured that the generator's			
					annunciator panel was hard			
					to normal power to indicate alarm conditions.			
					How other residents havin	g the		
	Generator Technic			potential to be affected by	-			
	bad charger and w			same deficient practice will	l be			
	The Generator Technician replaced the charger				identified and what correct			
	and battery leaving	and battery leaving the generator in working			action(s) will be taken;			
	condition.				Resident's that reside in the			
					facility have the potential to	be		
	e	finding was reviewed with the Administrator			affected.			
		ce Director during the exit			The Maintenance			
	conference.	onference.			Director/designee complete			
					load test on the generator o			
	3.1-19(b)				12/10/21 to ensure that it is	in		
					working order.			
					What measures will be put	into		
					place and what systemic			
					changes will be made to			
					ensure that the deficient			
					practice does not recur;			
					The Maintenance Director a			
					Designee were educated or			
			1		need to complete and docur	mont		

	R MEDICARE & MEDI		-		-	MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155359		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/29/2021			
	PROVIDER OR SUPPLIE		7519 V	ADDRESS, CITY, STATE, ZIP COD VINCHESTER RD WAYNE, IN 46819		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
K 0920	NFPA 101			the load test weekly and to any issues with the general immediately to the Executive Director by the Executive Director/Designee on 12/10 The Maintenance Director/designee will audit for compliance. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place; QAPI tool Preventative Maintenance will be complet weekly X 4 weeks, bi-month and monthly threreafter by Executive Director/Designet 100% threshold is not achief action plan will be presented the QAPI committee during monthly meeting.	e If eved an ed. This ed to	
SS=E Bldg. 01	Electrical Equipm Extens Electrical Equipm Extension Cords Power strips in a used for compon patient-care-relat (PCREE) assem assembled by qu the conditions of the patient care of non-PCREE (e.g except in long-te	patient care vicinity are only				

·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155359	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 11/29/2021	
	PROVIDER OR SUPPLIE		7	'519 W	ADDRESS, CITY, STATE, ZIP COD /INCHESTER RD NAYNE, IN 46819		
-					I		(110)
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſE	(X5) COMPLETIO DATE
	meet UL 1363A of for non-PCREE if (outside of vicinit non-patient care other UL standar used with general cords are not use wiring of a struct temporarily are r completion of the installed and me 10.2.3.6 (NFPA 9 (NFPA 70), 590.3 Based on observat failed to ensure 3 as a substitute for equipment with a NFPA-70/2011, 4 permitted in 400.7 not be used for (1) This deficient prace one smoke compa Findings include: Based on observat with the Maintena on 11/29/21 betwee refrigerator (high p plugged into and s in DON Office, B Medication Room of observation, the acknowledged pow to high power draw	or UL 60601-1. Power strips n the patient care rooms (y) meet UL 1363. In rooms, power strips meet rds. All power strips are al precautions. Extension ed as a substitute for fixed ure. Extension cords used emoved immediately upon e purpose for which it was ets the conditions of 10.2.4. (P9), 10.2.4 (NFPA 99), 400-8 3(D) (NFPA 70), TIA 12-5 ion and interview, the facility of 3 power strips were not used fixed wiring to provide power high current draw. 00.8 state unless specifically flexible cords and cables shall as a substitute for fixed wiring. etice could affect 30 residents in rtment. ions during a tour of the facility nce Director and Administrator ten 11:50 a.m. and 1:00 p.m., a power draw equipment) was supplied power by a power strip usiness Office, and the . Based on interview at the time e Maintenance Director wer strips were supplying power	K 0920		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/10/21 the Executive Director/designee ensured that power strips in the DON office, Business Office and Medicatio Room were removed. How other residents having t potential to be affected by the same deficient practice will b identified and what corrective action(s) will be taken; Resident's that reside in the facility have the potential to be affected. The IDT/designees completed Majestic Rounds in all areas of 12/10/21 to ensure that there w no items with a high current dr plugged into power strips. What measures will be put im place and what systemic changes will be made to ensure that the deficient	t the n he e e e n vere aw	12/10/202

	C OF HEALTH AND HU MEDICARE & MEDIC					FO	VTED: 12/16/20 VRM APPROVED 1B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155359		A. BU	A. BUILDING <u>01</u> B. WING			LETED	
		B. W.				/2021	
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	_	
MAJESTIC CARE OF FORT WAYNE			7519 WINCHESTER RD FORT WAYNE, IN 46819				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	3.1-19(b)				practice does not recur;		
					All staff were educated on the	е	
					importance of keeping items	with	
					a high current draw from beir	-	
					plugged into power strips by		
					Executive Director/Designee	on	
					12/10/21.		
					Majestic Rounds Ambassado		
					will round daily in order to en	sure	
					compliance.		
					How the corrective action(s will be monitored to ensure		
					deficient practice will not	the	
					recur, i.e., what quality		
					assurance program will be	nut	
					into place;	րու	
					QAPI tool Majestic Rounds w	vill he	
					completed weekly X 4 weeks		
					bi-monthly X 2 and monthly X		
					months by Executive		
					Director/Designee If 100%		
					threshold is not achieved an	action	
					plan will be developed. This		
					information will be presented	to	
					the QAPI committee during the		
					monthly meeting.		

FU8D21 Facility ID: 0

Facility ID: 000250

If continuation sheet F

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