PRINTED: 01/26/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		<del></del>	COMPLETED		
		155359	B. WING			01/06/2022		
				CTDEET A	DDDEGG CITY CTATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
					INCHESTER RD			
MAJEST	IC CARE OF FORT	I WAYNE		FORTV	VAYNE, IN 46819			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DECLIDED IN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	<b></b>	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
E 0000								
Bldg								
J	A Post Survey Rev	risit (PSR) to the Emergency	E 00	E 0000				
		ey conducted on 11/29/21 was						
	-	ndiana Department of Health						
	in accordance with	-						
	Survey Date: 01/0	6/22						
	Facility Number: 0	00250						
	Provider Number:							
	AIM Number: 100							
	111111111111111111111111111111111111111	20,500						
	At this PSR survey	, Majestic Care of Fort Wayne						
	-	liance with Emergency						
		irements for Medicare and						
		ting Providers and Suppliers,						
	-	ne facility has a capacity of 66						
		f 60 at the time of this survey.						
	and nad a census of	1 00 at the time of this survey.						
	Quality Paviany co	mpleted on 01/10/22						
	Quality Review co.	impleted on 01/10/22						
K 0000								
11.0000								
Bldg. 01								
Blug. 01	A Post Survey Rev	risit (PSR) to the Life Safety	K 00	000				
		on and State Licensure Survey	K U	)00				
		9/21 was conducted by the						
		it of Health in accordance 42						
	CFR Subpart 483.9							
	Crk Subpart 485.9	70(a).						
	Survey Date: 01/0	6/22						
	Survey Date. 01/0	0/22						
	Facility Number: 0	00250						
	Provider Number:							
	AIM Number: 100							
	Alivi inullider: 100.	20770U						
	At this DCD assesses	Majortia Cara of Fart Warma						
		, Majestic Care of Fort Wayne						
	was found not in co	ompliance with Requirements						
							<u> </u>	

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

TITLE

000250

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155359	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 01/06/2022		
NAME OF PROVIDER OR SUPPLIER  MAJESTIC CARE OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 7519 WINCHESTER RD FORT WAYNE, IN 46819				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	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 01/10/22					
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation, record review, and	K 0916	The battery on the generator v			
	interview, the facility failed ensure 1 of 1	K 0910	replace and a direct line of pov			

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Event ID:

FU8D22

Facility ID: 000250

If continuation sheet

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

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STATEME	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01		COMPLETED	
155359		B. WING		01/06/2022	
	100000	<del></del>		01/00/2022	
NAME OF PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
		7519 WINCHESTER RD			
MAJEST	IC CARE OF FORT WAYNE	FORT WAYNE, IN 46819			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	emergency generator annunciator panels were		was restored to the generato	r and	
	hard-wired to normal power to indicate alarm	panel.			
	conditions of the emergency or auxiliary power				
	in accordance with NFPA 99 6.4.1.1.17. This				
	deficient practice could affect all occupants.	The facility will ensure a re		ote	
			annunciator is hard-wired to		
	Findings include:		indicate alarm conditions of the		
			emergency power source		
	Based on an observation with the Maintenance		(generator) in a location readily observed by operating personnel. Ongoing, the Administrator or		
	Director on 11/29/21 it was discovered the				
	generator annunciator panel was not connected to				
	normal power only to battery power. Based on		designee will monitor the rem	note	
	records review with the Maintenance Director		annunciator to ensure continu	ued	
	and the Administrator on 01/06/2022 at 12:00		compliance 5 times per week	for 4	
	p.m., a service report from Safe Care stated they		weeks, weekly for 4 weeks and monthly for 3 months. Results of		
	were unable to hook up the panel to normal				
	power. Based on interview at the time of record		the monitoring will be reviewed during the facility's Quality		
	review, the Administrator stated the facility is				
	purchasing a new annunciator panel that can be		Assurance meeting; monitori	ng	
	hooked up to normal power and will be installed		will be ongoing		
	soon.				
	This deficiency was cited on 11/29/21. The				
	facility failed to implement a systemic plan of				
	correction to prevent recurrence.				
	The finding was reviewed with the Administrator				
	and the Maintenance Director during the exit				
	conference.				
	comerciae.				
	3.1-19(b)				

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If continuation sheet

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