STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155322	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of West Allen	6050 S Cr 800 E 92 Fort Wayne, IN 46814

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate a potential fall for 1 of 3 residents reviewed for accidents (Resident K).Findings include: On 7/24/25 at 1:06 P.M., Resident K's record was reviewed. Diagnoses included diabetes, generalized anxiety disorder, and dementia.An admission Minimum Data Set (MDS) assessment, dated 6/12/25, indicated a Brief Interview Mental Status (BIMS) was 8 indicating the resident had moderately impaired cognition. He required maximal assistance with his activities of daily living (ADL) including transfers, bed mobility, and toileting. He was frequently incontinent of bladder and occasionally incontinent of bowel.Care Plans indicated:-Revised 6/11/25: Resident K was at risk for falls or fall related injuries. He had signs of decreased judgement for safety and hadn't recognized his decline. The goal was for the resident to have reduced risk for fall and fall related injuries. Interventions included: resident was to use a rolling walker for short distances and wheelchair for long distance; staff to encourage and assist to wear non-skid footwear; provide cues as needed; and provide resident with 1 step commands/cues and allow to respond. -Revised 6/16/25: Resident K required assistance with his ADL's and needed encouragement to help with his care. The goal was for his ADL needs to be met daily with staff assistance. Interventions included: provide assistance with personal hygiene; provide assistance with ambulation-used a rolling walker and wheelchair; provide assistance with transfers.Care plans hadn't indicated the amount of assistance the resident required for his ADL's, if Resident K tried to do his own ADL's or walk around the room or to/from bathroom by himself. The fall care plan hadn't indicated he was at risk for falls due to unassisted transfers/ambulation nor were interventions put into place to prevent falls due to unassisted transfers, ambulation, or self-toileting.A progress note, dated 6/5/25 at 7:13 p.m., indicated the resident had arrived to the facility at 4:30 p.m., accompanied by his Power of Attorney (POA) and using a rolling walker. He was alert and verbally responsive. He had a small area of yellow and light purple bruising to his scalp, multiple areas of bruising and skin tear to the left forearm.A Skin Condition Evaluation, dated 6/6/25 at 5:26 p.m., indicated Resident K was admitted with 1 skin tear on his left forearm which measured 1 centimeter (cm) by 1 cm.A Behavioral Diagnostic Evaluation, dated 6/11/25, indicated Resident K had a history of depression, anxiety and dementia with psychosis prior to admission to facility. He had been at another nursing home but referred to this facility for memory care due to greatly declined cognition. He had auditory hallucinations and bizarre/illogical delusions. He was described as struggling with many behaviors since being here. He initially started out on the memory care unit but the noise from the severely demented residents was bothering him and he was threatening to hit the residents who were making noises.Nurse notes indicated:On 6/19/25 at 9:00 a.m., Resident K was walking in his room. Several attempts had been made to assist him with getting cleaning up but he refused. He went to the bathroom on his own and told staff to get out.On 6/30/25 at 1:00 p.m., Resident K was observed sitting on the 2nd bed in his (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room wearing no shoes or socks and skin injuries observed to his left arm. The nurse assessed the resident who was observed with 5 skin tears to his left arm. He had 3 small skin tears at his wrist, 1 to his forearm and 1 to the upper elbow. Resident K indicated he had not fallen but was unable to describe how the skin tears occurred. Treatments were applied to the skin tears and he was assessed with no further skin injuries observed. Staff initiated neurological checks despite the resident denying he had fallen or hit his head. An Interdisciplinary Team note, dated 7/1/25 at 11:18 a.m., indicated Resident K had a fall on 6/30/25 and received skin tears to his left wrist, left forearm and elbow. He had been observed barefoot. Staff were to encourage use of proper footwear and skin protectors applied.On 7/24/25 at 2:39 P.M., Resident K's POA was interviewed. She indicated the resident was hospitalized on [DATE], allegedly due to severe dehydration, electrolyte imbalances, and wound to his bottom. He was currently receiving hospice services at another facility. She indicated being told, the resident had a fall on 6/30/25 but indicated the resident rarely fell and hadn't known how he had gotten multiple skin tears.On 7/24/25 at 3:15 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed. Both were new to the facility and hadn't been employed at the facility when the incident occurred. The DON and ADON reviewed the fall report for Resident K on 6/30/25 and were unable to determine if the resident had an actual fall or if something else had occurred to cause his injuries. The fall report indicated the resident was wheelchair bound. Resident K's MDS had indicated he required maximal assistance with transfers so was unclear how he was observed seated on the other bed in his room with multiple skin tears. The resident had denied falling. The DON and ADON indicated circumstances surrounding the incident should've been thoroughly investigated to determine if the resident had fallen, what environmental factors were involved, and interviews done with staff to rule out another resident's involvement or staff member having witnessed the resident ambulating by himself in the room. On 7/25/25 at 10:30 A.M., the Administrator provided a current copy of the facility policy, titled Fall Prevention which indicated each resident would be assessed for fall risk and receive care and services to minimize the likelihood of falls .A fall was an event where the individual unintentionally came to rest on the ground, floor or other level but not as a result of an overwhelming external force (resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground and can occur anywhere .When any resident experiences a fall, the facility will assess the resident, complete a post fall assessment and incident report, notify the physician and family, review the resident's care plan and update as indicated, document assessments and actions and obtain witness statements in the case of injury.This Citation relates to Complaint 18070993.1-45(a)