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	03/09/2026

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 - Immediate jeopardy to resident health or safety 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 observation, interview and record review, the facility failed to ensure staff used the correctly sized sling, in good working condition, when transferring a resident with a mechanical lift for 1 of 3 residents reviewed for assistive device use (Resident G). This failure resulted in the resident falling from the lift when a strap on the sling broke causing the resident to fall sustaining multiple fractures of neck, lower back, and pelvis. This resulted in Resident G's death. The immediate jeopardy began on [DATE] when the facility failed to ensure a lift sling was properly sized and in good working condition. The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional Nurse Consultant Director were notified of the Immediate Jeopardy on [DATE], at 1:45 P.M. The immediate jeopardy was removed on [DATE], and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore Past Noncompliance. Findings include:A hospital report, dated [DATE], alleged Resident G was being lifted using a Hoyer lift. While transferring, the resident fell out of the lift, striking his head against the bed frame and landing directly onto the floor. He was sent to the hospital where he was diagnosed with multiple fractures. According to the report, the resident succumbed to his injuries and died in the hospital. This resulted in Immediate Jeopardy/ Substandard Quality of Care. On [DATE] at 1:08 P.M., Resident G's record was reviewed. Diagnoses included hemiplegia affecting left side and above knee left leg amputation. There was no evidence in the record of terminal illness, hospice, or bone density issues. A Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident G's height was 78 inches (6 feet 6 inches) and his weight 252 pounds. A current care plan, revised [DATE], indicated Resident G required staff assistance with transfer into and out of his Broda chair using a Hoyer (mechanical) lift and 2 staff. The care plan did not indicate the size of the sling to be used when transferring Resident G. There were no notes to indicate there were concerns with smoking, falls, injuries or altercations. A current physician order, dated [DATE], was to utilize a Hoyer lift for transfers with 2 staff. There were no other notes related to diagnosis contributing to multiple fractures. There were no physician orders to indicate the size of sling to be used when transferring Resident G. There was no assessment by the Interdisciplinary Team to indicate sizing of the sling had been evaluated prior to utilizing the lift. A progress note, dated [DATE] at 11:55 a.m., indicated the Licensed Practical Nurse (LPN) 2 and Certified Nurse Aid (CNA) 4 were transferring Resident G from his bed to chair with the Hoyer lift when the transfer sling strap on the left side by the left leg malfunctioned. The resident fell from the Hoyer lift, hitting his head on his roommate's bed frame. He had a short loss of consciousness followed by alertness with lethargy and complaints of pain. He was assessed immediately and vital signs taken with the following results: Blood Pressure (B/P) 107/63 (normal B/P-120/80); Pulse (P)-65 (normal 60-100 beats per minute); Respirations (R)-16 (normal 16-20); Temperature (T) 97.0; and Blood Oxygenation 95% (normal 90% and higher). He had no visible injuries. The Nurse Practitioner (NP) was notified and gave orders to send the resident to the hospital for further evaluation. Hospital notes, dated [DATE], indicated the resident complained of pain in his neck and back. CT scans indicated the resident had multiple fractures to his lower back, pelvis, and neck. On [DATE] at 10:30 (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A.M., the Administrator provided a copy of Joerns Hoyer HPL500 user instruction manual. The manual indicated the user should always check the sling to ensure suitability for the particular patient, was of the correct size, capacity, and to always fit the sling according to the instructions provided (user instructions). On [DATE] at 11:33 A.M., Certified Nurse Aid (CNA) 4 was interviewed. She indicated the sling straps were inspected prior to utilizing the lift, but did not show any wear. She indicated she and LPN 2 were transferring Resident G using the mechanical lift when the sling strap broke. CNA 4 indicated the resident used a blue colored sling with 4 straps, each with colored rings. The rings attached to the mechanical lift bar using the the color coding to provide stability. Prior to the transfer, the sling pad was placed under the resident, and the straps were attached to the lift bar by the last black ring on each strap. After securing the resident with the straps, CNA 4 lifted Resident G off the bed and began moving the lift backward when the black ring of the left bottom strap came apart in the middle of the strap, causing the resident to fall. CNA 4 indicated the sling and sling straps had not appeared in poor condition but were old. When asked, she indicated there was no specific sized sling to use for Resident G or any of the residents and all the slings in the facility were the same. On [DATE] at 11:45 A.M., Licensed Practical Nurse (LPN) 2 was interviewed. LPN 2 was present in the resident's room when he was transferred with the mechanical lift. The sling strap came apart in the middle on the left leg side causing Resident G to fall from the sling, striking his head on his roommate's bed frame and landing on his back. The resident immediately complained of pain in the back of his head, back and hips. He lost consciousness briefly but came to. He was lethargic and not acting like himself. She immediately notified the Nurse Practitioner (NP) and orders were given to send Resident G to the emergency room for evaluation and treatment. On [DATE] at 12:20 P.M., the mechanical lift sling with the broken strap to fall was observed in the Administrators office. The sling was blue in color with blue binding and pilling at the edges of the entire outer perimeter. There were no frays or tears on the body of the sling. The black ring on the left (leg) bottom strap was torn in half in the middle of the ring. A worn, torn partial label with no observable writing was on the body of the sling. There was no visible label or tags identifying the size of the sling or directions for use. The Administrator indicated the sling was the sling utilized by LPN 2 and CNA 4 to lift Resident G and was a size large. On [DATE] at 12:25 P.M., the Administrator provided a copy of information on the sling, purchased [DATE]. The information included a weight and height sling chart. The chart indicated a size large universal sling was for patients with a weight range from 225 pounds to 325 pounds and height range from 5 feet 5 inches to 6 feet 1 inch. Product details indicated the sling size and fit could vary significantly depending on a patient's weight and girth. These were general guidelines and the physician was to be consulted before sling selection. On [DATE] at 12:37 P.M., CNA 6 was interviewed. She indicated prior to Resident G's fall, sling lifts used in the facility were old and residents had no size assigned to them to be used for mechanical lift transfers. She indicated Resident G was a big man. Staff had to attach the mechanical lift sling straps by the last black ring on each strap to fit his size. She indicated staff checked the slings for use, but did not know who monitored the slings for age and defects. On [DATE] at 2:14 P.M., the Rehabilitation Director was interviewed. She indicated the rehabilitation department provided evaluations for need of mechanical lifts for safe transfers. The department was not responsible for fitting and determining the correct size of sling pad to be used. When asked how staff would know which sized sling pad to use for a resident, she indicated staff should follow the label directions on the sling pad for the appropriate size. She indicated she did not know who monitored the slings for age or defects. In an interview on [DATE] at 10:17 A.M., the Coroner indicated she did not have hospital records to complete a death certificate. She indicated the emergency room indicated Resident G received back, pelvis, neck fractures and succumbed to his injuries. A Safety Guide for Patient Lifts was retrieved, on [DATE], from the Federal Drug Administration website, www.fda.gov. The safety guide indicated to select a patient's sling size, the following should be considered: Assess the patient's size, weight and hip measurement and choose size of sling based on manufacturer recommendation for patient's (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	measurements. Choosing the correct sling size was critical for safe patient transfers. Using the wrong sling or attaching the sling incorrectly could cause an accident resulting in serious injury or death. Prior to use, the sling should be examined for attachment tears, holes, and frayed seams. If the sling shows signs of wear, it should be replaced immediately. A guide to identifying sling deterioration, undated, retrieved from the Proactive website, www.proactivemedical.com indicated straps may appear to be in good condition, but may be compromised under several conditions, including missing, faded, or illegible tags on the sling. A current facility policy, titled Transfers and Mechanical Lifts, was provided by the DON on [DATE] at 2:12 P.M. The procedure indicated the facility would ensure appropriate amounts of varying sizes of slings to accommodate residents and residents would be measured correctly as per manufacturer's instructions on proper sling sizing. Slings found to be damaged, broken or unsafe would be removed from service and replaced. The immediate jeopardy was removed on [DATE], the deficient practice corrected on [DATE] when the facility removed all lift pads from service, assessed residents utilizing lifts for proper fit according to manufacturer's guidelines, replaced all sling with properly sized slings, added sling sizing to care plans and care guidance for CNAs, developed a replacement schedule for slings according to manufacturer's instructions, and reeducated staff on how to identify deterioration of sling pads before use prior to the start of the survey and was therefore Past Noncompliance. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)