

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825
--	--

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/22/14</p> <p>Facility Number: 000541 Provider Number: 155475 AIM Number: N/A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Towne House Retirement Community was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a walkout lower level below the southeast wing 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 and in areas open to the corridors. Battery</p>	K010000		

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825
--	--

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010025 SS=E	<p>operated smoke detectors were installed in the resident rooms. The facility has a capacity of 99 and had a census of 60 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except the elevator equipment room. The facility had a detached barn providing facility services including storage of mowers, maintenance equipment and two buses that was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825
--	--

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010038 SS=E	<p>ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 1 of 6 upper level smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation on 07/22/14 at 3:00 p.m. with the Director of Environmental Services, there was a one half inch unsealed ceiling penetration in the Activity's office closet around computer lines. This was acknowledged by the Director of Environmental Services at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 upper level</p>	K010025	The Towne House does not agree with this finding, but as a requirement of participation in the Medicare program, the community will provide the following plan of correction. The 1/2 inch ceiling penetration in the activities director's office was repaired on the day of the survey. Smoke barriers will be monitored and included in the maintenance department quality assurance program. The environmental services director will monitor compliance.	08/21/2014
		K010038	The Towne House does not agree with this finding, but as a requirement of participation in the	08/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/22/2014
NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K010046 SS=E	<p>exit doors in the path of egress, equipped with a magnetic locking system, remained unlocked with activation of the building fire protective signaling system. LSC 19.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Environmental Services on 07/22/14 at 3:50 p.m., the temporary main dining room exit door, which was equipped with a magnetic locking system, failed to remain unlocked when the fire alarm system was placed in silence mode. This was acknowledged by the Director of Environmental Services at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p>		<p>Medicare program, the community will provide the following plan of correction. There is a construction project currently in process that has required the community to temporarily use a different emergency exit. The construction project should be completed in Oct 2014. In the meanwhile, the community is obtaining the necessary magnetic locks that unlock upon activation of the fire alarm system to be in compliance. The environmental services director will monitor compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/22/2014
NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K010048 SS=C	<p>Based on observation and interview, the facility failed to provide exterior emergency lighting for 1 of 5 upper level exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 1 of 6 upper level smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Director of Environmental Services on 07/22/14 at 2:10 p.m., there was not an exterior light fixture at the temporary exit from the upper level dining room. Based on an interview with the Director of Environmental Services at the time of observation, he stated this exit was being used temporarily during construction of an addition extending out from the service hall and he confirmed the temporary dining room exit lacked an exterior exit light.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p>	K010046	<p>The Towne House does not agree with this finding, but as a requirement of participation in the Medicare program, the community will provide the following plan of correction. There is a construction project currently in process that has required the community to temporarily use a different emergency exit. The construction project should be completed in Oct 2014. In the meanwhile, the community is obtaining the necessary exterior lighting to be in compliance. The environmental services director will monitor compliance</p>	08/21/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/22/2014
NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on record review and interview, the facility failed to provide a written plan that included the activation of a resident room battery operated smoke detector in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on a record review with Director of Environmental Services on 07/22/14 at 1:48 p.m., the "Disaster Plan" did not address the activation of a resident room battery operated smoke detector. This was acknowledged by the Director of Environmental Services at the time of record review.</p> <p>3.1-19(b)</p>	K010048	<p>The Towne House does not agree with this finding, but as a requirement of participation in the Medicare program, the community will provide the following plan of correction. The community has a fire plan that is routinely practiced and as part of the plan, staff members provide back up calls to the fire department when the alarm is sounded. Also, there are smoke detectors in the hallways that are connected to the fire alarm system that connect automatically to the fire department. The policy did not specifically address the battery operated smoke alarms in the resident rooms. The fire plan has been modified so that if a battery operated smoke alarm is activated, an employee will pull the closest fire alarm and activate the system. Back up calls to the fire department will be made as normal. The new policy will be made available to staff and the plan will be practiced in routine fire drills. The environmental services director will monitor compliance.</p>	08/21/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825
--	--

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 oxygen cylinders in the west wing clean utility room were properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b)27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any residents near the west wing clean utility room.</p> <p>Findings include:</p> <p>Based on an observation and interview with the Director of Environmental Services on 07/22/14 at 3:25 p.m., he acknowledged there were three unsupported cylinders of compressed oxygen in the west wing clean utility room.</p>	K010076	The Towne House does not agree with this finding, but as a requirement of participation in the Medicare program, the community will provide the following plan of correction. The oxygen cylinders were removed from the utility room on the day of the survey. The cylinders were placed there by one of the hospice providers without authorization of the community. Communication was made to each hospice regarding the use and placement of this equipment. In the future, this equipment will be stored with the community's oxygen containers in the approved oxygen room. The safety inspection portion of the quality assurance program has been updated and modified to include the reievw of appropriate storage of the oxygen containers. The environmental services director and director of nurses will monitor for compliance.	08/21/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/22/2014	
NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010147 SS=D	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 resident in resident room 312.</p> <p>Findings include:</p> <p>Based on observation and interview with the Director of Environmental Services on 07/22/14 at 2:55 p.m., he acknowledged and removed a light weight extension cord that was plugged in and providing power to a decorative tree in resident room 312.</p> <p>3.1-19(b)</p>	K010147	The Towne House does not agree with this finding, but as a requirement of participation in the Medicare program, the community will provide the following plan of correction. The extension cord was removed from the room on the day of the survey. There currently is a quality assurance program in place that addresses the use of extension cords. However, at times, residents and residents' families still bring those items into the community. A reminder to residents and families will be included in the next community newsletter that the use of extension cords is prohibited. In addition, an in-service will be held with the maintenance and housekeeping departments to remind them that extension cords are prohibited. The environmental services director will monitor compliance.	08/21/2014			

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

PRINTED: 08/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155475	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER  TOWNE HOUSE RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	