

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835
--	--

(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: 07/08/14</p> <p>Facility Number: 000260 Provider Number: 155679 AIM Number: 100267820</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Bethlehem Woods Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 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 was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in</p>	K010000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post survey revisit on or before July 18, 2014.	

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: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835
--	--

(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
K010018 SS=E	<p>the resident rooms. The facility has a capacity of 90 and had a census of 87 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance shed used to store maintenance supplies and a shed used for storage of paperwork.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/10/14.</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 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/08/2014
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835		
(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>permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 19 resident room corridor doors on the 300 hall closed and latched into the door frame. This deficient practice could affect any of the 37 residents on the 300 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/08/14 at 12:46 p.m., the corridor door to resident room 309 failed to latch into the door frame. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010018	<p>It is the practice of this facility to ensure that all resident room corridor doors close and latch into the door frames, including resident room door 309. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were negatively affected by this alleged deficient practice. The Maintenance Supervisor immediately contacted a contractor that came into the facility on July 10th and adjusted resident room door 309 so that it closed and latched properly. The Maintenance Supervisor was present during this contractor's assigned work and ensured the door closed and latched properly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: No residents were negatively affected by the alleged deficient practice. The Maintenance Supervisor checked all other resident room doors on July 10th, 2014 and found no other resident room doors not to close and latch properly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: On July</p>	07/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/08/2014
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835		
(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	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 Based on observation and interview, the facility failed to ensure 1 of 6 exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) requires an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. This deficient practice could affect any residents	K010038	9, 2014, the Executive Director re- inserviced the Maintenance Supervisor on the Life Safety Code Regulation LSC 19.3.6.3 as it pertains to doors provided with a means suitable for keeping the door closed. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: During the Maintenance Supervisor's weekly safety rounds, all resident room doors will be checked to ensure that they close and latch properly. Any identified issues will be fixed immediately. This documented Life Safety Code CQI audit will take place weekly and will be submitted to the monthly CQI meeting for review. Systemic changes were completed on July 10, 2014 It is the practice of this facility to ensure that exit doors are readily accessible. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: No residents were negatively affected by this alleged deficient practice. On July 9th, 2014, the Maintenance Supervisor had a contractor come to fix the 300 hall exit door so that	07/09/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/08/2014
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835		
(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>evacuated through the service hall from the main dining room in the event of an emergency. This deficient practice could affect any of the 37 residents on the 300 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/08/14 at 12:41 p.m., the exit door at the end of the 300 hall was equipped with an electromagnetic lock. When the Maintenance Supervisor applied force to the door for one minute, there was an alarm but the door failed to release. A sign on the door indicated it would release in 15 seconds. The door did release when the code was entered and upon activation of the fire alarm system. The Director of Maintenance acknowledged the exit door did not release after one minute.</p> <p>3.1-19(b)</p>		<p>the lock releases within 15 seconds upon application of a force to the release device. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions will be taken: No residents were negatively affected by the alleged deficient practice. The exit door on 300 hall has been adjusted so the lock releases within 15 seconds upon application of force. The Maintenance Supervisor checked all exit doors on July 9, 2014 and ensured they all released within 15 seconds of applied force to the release device. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: On July 9th, 2014 the Executive Director re-inserviced the Maintenance Supervisor on the Life Safety Code Regulation LSC 7.1 19.2.1 as it pertains to the requirement for all exit doors to be readily accessible at all times for exit access. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: During the Maintenance Supervisor's weekly safety rounds, all exit doors will be checked to ensure they open within 15 seconds when force is applied to the release device. Any identified issues will be fixed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835
--	--

(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
K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 5 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect residents in 3 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 07/08/14 from 12:33 p.m. to 1:20 p.m., the 200 hall and the 300 hall fire door sets failed to latch into the frame when tested.</p>	K010044	<p>immediately. This documented Life Safety Code CQI audit will take place weekly and will be submitted to the monthly CQI meeting for review. Systemic changes were completed on July 9, 2014</p> <p>It is the practice of this facility to ensure that all fire door sets are arranged to automatically close and latch. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected by this alleged deficient practice. The Maintenance Supervisor had a contractor come to the facility on July 10th, 2014 and adjusted the 200 hall and 300 hall fire door sets to ensure they latched into the frames when tested. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No residents were negatively affected by the alleged deficient practice. The Maintenance Supervisor checked all fire door sets in the facility on July 10th and made sure they all closed and latched into the frames when tested. What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	07/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/08/2014
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835		
(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	
K010130 SS=E	<p>Based on an interview with the Maintenance Supervisor at the time of observations, he confirmed these were fire doors and had recently been replaced.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetrations in 3 of 5 fire barrier walls were maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts,</p>	K010130	<p>practice does not recur: On July 9th, 2014 the Executive Director re-inserviced the Maintenance Supervisor on the life safety code regulations and NFPA 80 regulations as they pertain to ensuring that fire door sets are arranged to automatically close and latch. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: During the Maintenance Supervisor's weekly safety rounds, all fire door sets will be checked to ensure that they automatically close and latch. Any identified issues will be fixed immediately. This documented Life Safety Code CQI audit will take place weekly and will be submitted to the monthly CQI meeting for review. Systemic changes were completed on July 10, 2014.</p> <p>It is the practice of this facility to ensure that all unsealed penetrations in fire barrier walls are maintained to ensure the fire resistance of the barrier. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were negatively affected by this alleged deficient practice. The Maintenance</p>	07/09/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/08/2014	
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835			
(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>cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 07/08/14 from 2:00 p.m. to 2:12 p.m., there were unsealed penetration around the call</p>		<p>Supervisor had a contractor come into the facility on July 9, 2014 and re-caulk the un- sealed penetrations around the call system wiring above the drop down ceiling tile at the fire barrier walls at the service hall fire doors, the D wing fire doors and the 300 hall fire barrier doors. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No residents were negatively affected by the alleged deficient practice. The Maintenance Super- visor double checked that the contractor sealed all penetrations in the fire barrier walls before the contractor left the facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Executive Director re-inserviced the Maintenance Supervisor on July 9, 2014 on the Life Safety Code Regulation as it pertains to the need to ensure that all fire barrier walls are free from unsealed penetrations and are filled with an approved material that is capable of maintaining the fire resistance of the fire barrier. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: During the Maintenance Supervisor's weekly safety rounds, all fire barrier walls</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/08/2014
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835		
(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>system wiring above the drop down ceiling tile at the following fire barrier walls:</p> <p>a. measuring one fourth inch at the service hall fire doors,</p> <p>b. measuring one fourth inch at the D wing fire doors,</p> <p>c. measuring one inch at the 300 hall fire barrier doors.</p> <p>Measurements were provided by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>will be viewed and checked to ensure no unsealed penetrations exist. Any identified issues will be fixed immediately. This documented Life Safety Code CQI audit will take place weekly x 4 weeks, monthly x 3 months, then quarterly thereafter. This CQI audit will be submitted to the monthly CQI meeting for review. Systemic changes were completed on July 9, 2014.</p>		