STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155475	A. BUILDING -- B. WING	06/20/2024

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/20/24 Facility Number: 000541 Provider Number: 155475 AIM Number: N/A At this Emergency Preparedness survey, Towne House Retirement Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 32 Medicare only beds and had a census of 10 at the time of this survey. Quality Review completed on 06/27/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/20/24 Facility Number: 000541 Provider Number: 155475 AIM Number: N/A At this Life Safety Code survey, Towne House Retirement Community was found not in	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission that Towne House Retirement Community provides anything other than a high quality of care to its residents. Towne House considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in senior living. We believe that any	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hayley Carr	Executive Director	07/12/2024

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	compliance with Requirements 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 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 areas open to the corridors. Battery operated smoke detectors were installed in the resident rooms. The facility has a capacity of 32 Medicare beds and had a census of 10 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached barn providing facility services including storage of mowers, maintenance equipment and two buses that was not sprinklered. Quality Review completed on 06/27/24		feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents. As required the facility submits the following plan of correction: The Towne House is requesting paper compliance.	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on observation, records review, and interview; the facility failed to ensure staff were instructed in the use of the UL 300 hood system, had posted signs with instructions for manually operating the fire extinguishing system, emptying the grease drip pans when full or overflowing, and prevent baffles from becoming heavily contaminated with grease or oily sludge in 1 of 1 Kitchens. Cooking equipment is protected in accordance with NFPA 96. A.) 11.1.4 states instructions for manually operating the fire extinguishing system shall be	K 0324	This deficiency was cited due to a kitchen employee not being properly trained on how to activate the hood suppression system, proper signage not being posted for the Class K fire extinguisher, and hood and grease drip pan cleaning not being adequate per NFPA. Proper signage for the use of the Class K fire extinguisher was replaced in the kitchen. An	07/12/2024

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	posted conspicuously in the kitchen and shall be reviewed with employees by management. B.) 11.6.2 states hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. This deficient practice could affect staff in the kitchen and all residents in the dining room. Findings include: A.) Based on observation with the Executive Director (ED), Assistant Executive Director (AOD), and Director of Environmental Services (DES) on 06/20/24 at 2:31 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher without the required posted instructions conspicuously located in the kitchen. Based on interview, the dietary staff #1 was asked how to activate the hood suppression system if there was a grease fire underneath the hood. The staff member pointed to a red push button that was not the suppression activation station and stated she was not sure how to activate the suppression system. The DES acknowledged the staff member response, stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment, and confirmed the required instructional signs were not posted in the kitchen. B.) Based on records review with the Executive Director (ED), Assistant Executive Director (AOD), and Director of Environmental Services (DES) on 06/20/24 at 2:31 p.m., the hood cleaning form dated 04/06/24 stated the drip pans were overflowing with grease and should dump the pans in-between cleaning service. The cleaning from 11/13/23 also stated the drip pans were overflowing, the baffle above the deep fat fryer		in-service was held with dining staff on 6/21/24 and staff were educated on kitchen fire safety. Work orders were placed in our work order system to track proper cleaning. Kitchen grease drip pans will be cleaned weekly. Kitchen hood filters will be cleaned monthly. The deficiency could affect staff and residents in the dining room. No residents or staff have been adversely affected. To monitor corrections, an environmental rounds audit will be completed weekly and findings will be reviewed at QAPI meetings quarterly for at least 6 months and will continue if 100% compliance is not achieved. For paper compliance request please see Attachment A – Kitchen Files.	

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	was heavily covered with grease and oily sludge, and recommends the baffles should be rotated to prevent build up. Based on observation of the hood system and components, there was mild grease buildup, but the facility currently is not following the recommendation from the cleaning service. Based on interview during records review and observation, the DES agreed with the cleaning services report and recommendations. He also stated the facility is currently not cleaning the drip pans or rotating the baffles in-between professional cleanings and will create a monthly form to follow the recommendations. The finding was reviewed with the ED, AED, and DES during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure 1 of 1 outside exit overhangs/attached decking were provided with sprinkler coverage in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems 2010 edition. Section 8.15.7.1 states unless the requirements of 8.15.7.2, 8.15.7.3, or 8.15.7.4 are met, sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft (1.2 m) in width. This deficient practice could affect five residents using the fitness center exit. Findings include: Based on observation with the Executive Director (ED), Assistant Executive Director (AOD), and Director of Environmental Services (DES) on	K 0351	This deficiency was cited due to an outdoor area with a deck overhang not having sprinkler coverage. Our licensed fire system contractors were contacted on 6/21/24 and we are currently waiting for a new sprinkler head to be added to the covered area. The contractors estimate the work to be done on 7/20/24. The deck is above a ground floor therapy area back exit and no residents were in the therapy gym at the time of the survey. No residents were adversely affected. To monitor corrections, the fire system will be inspected by our	07/20/2024

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	06/20/24 at 3:05 p.m., outside the fitness center exit there was decking attached to the building for the top story which measured seven feet by six feet directly over the exit concrete pad that did not have sprinkler protection. Based on an interview at the time of observation, the DES agreed the decking was attached to the building directly over the exit door, did not have sprinkler protection, and provided the measurements of the decking. The finding was reviewed with the ED, AED, and DES during the exit conference. 3.1-19(b)		licensed fire system contractor to ensure full functioning once the sprinkler head has been installed. The inspection reports shall be shared and reviewed at QAPI on a quarterly basis for at least 6 months and will continue if 100% is not achieved. For paper compliance request please see Attachment B – Sprinkler Head.	
K 0353 SS=C Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 4 of 8 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Executive Director (ED), Assistant Executive Director (AOD), and Director of Environmental Services (DES) on 06/20/24 at 2:16 p.m., the facility's sprinkler systems had eight pressure gauges but	K 0353	This deficiency was due to sprinkler system gauges not being replaced every 5 years or documented as tested every 5 years with a calibrated gauge. Our licensed fire system contractors were contacted, and the gauges were replaced. No residents, staff or visitors were adversely affected. To monitor corrections, in addition to our fire system inspections, a work order was placed in our work order system to track that no gauges are older than 5 years. The gauges will be checked monthly and if issues are found, our contractor will be notified. Findings will be reviewed at QAPI meetings quarterly for at least 6 months and will continue if 100% compliance is not achieved. For	07/12/2024

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	four of the gauges were dated 2018, and no recalibration date information was affixed to the sprinkler system gauges. Based on interview at the time of the observations, the DES agreed four of eight gauges were older than five years and were not recalibrated. The finding was reviewed with the ED, AED, and DES during the exit conference. 3.1-19(b)		paper compliance request please see Attachment C – 5 year gauges.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the elevator mechanical room was inspected annually according to NFPA 10, (2010) Section 7.3.1.1.1 which requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. This deficient practice could affect 5 residents in the therapy gym smoke compartment. Findings include: Based on observation with the Executive Director (ED), Assistant Executive Director (AOD), and Director of Environmental Services (DES) on 06/20/24 at 3:05 p.m., the tag on the fire extinguisher in the elevator mechanical room by therapy had an annual inspection date of January of 2023 while all other fire extinguishers in the building had an inspection date of January 2024. Based on interview at the time of observation, the DES stated it is most likely the extinguisher was missed during the annual inspection.	K 0355	This deficiency was cited due to an annual inspection being missed on one fire extinguisher in the elevator mechanical room. The fire extinguisher was inspected by our licensed fire system contractor following the survey. The elevator mechanical room was on the ground floor and no residents were on the ground floor at the time of survey thus no residents were adversely affected. To monitor corrections, in addition to our fire system inspections, a work order has been placed in our work order tracking system to examine fire extinguisher tags on an annual basis. The reports will be submitted to QAPI to monitor compliance. For paper compliance request please see Attachment D – Annual Fire Extinguisher.	07/12/2024

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	The finding was reviewed with the ED, AED, and DES during the exit conference. 3.1-19(b)			
K 0781 SS=D Bldg. 01	NFPA 101 Portable Space Heaters Based on record review, observation, and interview; the facility failed to enforce the portable space heater policy to ensure heaters are inspected and did not exceed 212 degrees for 1 of 1 portable space heaters used in staff areas. This deficient practice could affect 2 staff in the Assessment Coordinator office Findings include: Based on records review with the Executive Director (ED), Assistant Executive Director (AOD), and Director of Environmental Services (DES) on 06/20/24 at 3:19 p.m., the space heater policy does allow space heaters in staff areas with proper maintenance and testing. Based on observation at 2:09 p.m., there was no affixed label on the portable space heater in the Assessment Coordinator office ensuring the heater does not exceed 212 degrees and receive proper testing and maintenance. Based on interviews at the time of observation and records review, the DES stated space heaters are allowed in staff areas but the portable space heater in the Assessment Coordinator office was not inspected and tested before use. The finding was reviewed with the ED, AED, and DES during the exit conference. 3.1-19(b)	K 0781	This deficiency was cited due to a staff member having a portable space heater in their office. It was not operating at the time it was found and the office was locked and closed at the time of the survey. The portable space heater was removed at the time of the survey. The electric heaters policy was updated, the staff member was educated regarding the electric heaters policy. The interdisciplinary team was in-serviced on 7/9/24 that portable space heaters are not permitted. The area identified was East wing where no residents reside thus none were affected. To monitor corrections, an environmental rounds audit will be completed weekly and findings will be reviewed at QAPI meetings quarterly for at least 6 months and will continue if 100% compliance is not achieved. If space heaters are found, they will be removed immediately, and education will be provided. For paper compliance request please see Attachment E – Portable Space Heaters.	07/12/2024

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