STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155658	A. BUILDING -- B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEY MANOR HEALTH CENTER	1555 N MAIN ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/02/24 Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 At this Emergency Preparedness survey, Wesley Manor Health Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 96 certified beds. At the time of the survey, the census was 92. Quality Review completed on 07/03/24	E 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on July 17, 2024.	
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).	K 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary BRENT Waymire	Executive Director/Administrator	07/16/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Survey Date: 07/02/24 Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 At this Life Safety Code survey, Wesley Manor Health Center was found not in 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 facility was surveyed as two buildings because of different construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement was determined to be Type II (222) construction. The G and H wings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility has a capacity of 96 and had a census of 92 at the time of this survey. All areas which provide customary access to residents were sprinklered. All areas which provide facility services such as the laundry, generator room, boiler room and the maintenance department were not sprinklered. Quality Review completed on 07/03/24		these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on July 17, 2024.	
K 0000 Bldg. 02				

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	155658	A. BUILDING 02 B. WING	07/02/2024

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	Quality Review completed on 07/03/24			
K 0374 SS=E Bldg. 02	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 16 residents, 4 staff and 2 visitors. Findings include: Based on observation made during a tour of the facility on 07/02/24 at 1:56 p.m. with the Maintenance Supervisor, the F hall set of smoke barrier doors nearest to Resident room #112 would not fully close or latch into the doorframe leaving a one-inch gap along the center where the doors	K 0374	It is the policy of Wesley Manor to ensure barrier doors will restrict the movement of smoke for at least 20 minutes, and that doors to smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation, in accordance with the life safety code. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The barrier door labeled as F112 was adjusted immediately following the life safety visit at approximately 3:00 PM on July 2, 2024, by the maintenance staff, so that it would fully close and latch, (see Attachments – K 374-A-1, K	07/17/2024

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	came together in the closed position. This was verified by the Maintenance Supervisor at the time of observation who stated that he would have one of his staff make an adjustment to the door closer as soon as possible. This item was again discussed at the exit conference held on 07/02/24 at 2:40 p.m. with the Maintenance Supervisor and the facility Administrator present. 3.1-19(b)		374-A-2, and K 374-A-3). While the barrier door adjustment was successful, it was felt that the door closure to this barrier door labeled as F112 was failing and a new door closure was installed on July 3, 2024. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on July 3, 2024, of all the barrier doors located in the health center, to verify that all doors fully closed and latched. Two additional barrier doors were noted to not latch; barrier doors identified as GG15 and G103. The barrier door labeled as G103 was adjusted immediately and the barrier door labeled as GG15 required that a new latch be ordered. The latch was ordered on July 3, 2024, was received on July 11, 2024, and installed on July 11, 2024, (see Attachment – K 374-B). What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor will inspect barrier doors weekly for eight (8) weeks to assure compliance and then continue its practice of inspecting barrier doors monthly, (see Attachments – K 374-C-1, and K 374-C-2). Barrier doors which are found that do not fully close, latch, or meet the provisions of the life	

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			safety code will be repaired immediately upon discovery. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? Through routine and random rounds, the Maintenance Director will review Barrier doors to assure that they close fully, latch and meet the applicable requirements of the life safety code. The results of the Barrier Door Weekly Inspection audits will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) for Safety which is held one time monthly for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	