]	DEPARTMENT OF HEALTH AND HUMAN SERVICES									
(CENTERS FOR MEDICARE & MEDICAID SERVICES									
	STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	_						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		A. BU	A. BUILDING B. WING			COMPLETED 08/03/2023	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		2237 E	ADDRESS, CITY, STATE, ZIP COD INGLE RD WAYNE, IN 46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/03/23 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 At this Emergency Preparedness survey, Englewood Health & Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 67 certified beds. At the time of the survey, the census was 50. Quality Review completed on 08/08/23		E 0	000	The following plan of correction constitutes our written allegation of compliance for the deficiency cited. Submission of this plan correction is not an admission the deficiency exists or that on was cited correctly. This plan correction is submitted to meet the requirements established in State and Federal law. This facility respectfully request paper compliance for the deficiencies cited.	on cies of that se of t	
E 0037 SS=C Bldg	441.184(d)(1), 482.15(d)(1), 483.475(d)(1),						

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

(X6) DATE

TITLE

Rose Smalley Regulatory Compliance Director 08/24/2023

Any defiency statement 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 disclodays 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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i i i i i i i i i i i i i i i i i i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		155654	B. W	ING		08/03	2023
NAME OF F	PROVIDER OR SUPPLIER	· }	-		ADDRESS, CITY, STATE, ZIP COD		
					NGLE RD		
ENGLEW	VOOD HEALTH & F	REHABILITATION CENTER		FORT V	VAYNE, IN 46809		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 2, "Organizations" under		TAG	DE TELEKET I		DATE
	_	at §486.360, RHC/FQHCs					
	at §491.12:]	at 3400.000, 1110/1 Q1103					
		ram. The [facility] must do					
	all of the following						
	(i) Initial training ir	n emergency preparedness					
	policies and procedures to all new and						
	_	viduals providing services					
		nt, and volunteers,					
		eir expected roles.					
	(ii) Provide emergency preparedness training at least every 2 years.						
	(iii) Maintain documentation of all emergency						
	preparedness training.						
		staff knowledge of					
	emergency proce						
	(v) If the emergen	cy preparedness policies					
	and procedures a	re significantly updated, the					
		duct training on the					
	updated policies a	and procedures.					
	*[For Hospices at	§418.113(d):] (1) Training.					
		do all of the following:					
	(i) Initial training ir	n emergency preparedness					
	· ·	edures to all new and					
		mployees, and individuals					
		under arrangement,					
		eir expected roles.					
	(ii) Demonstrate s	_					
	emergency proce	gency preparedness training					
	at least every 2 years. (iv) Periodically review and rehearse its						
	emergency preparedness plan with hospice						
	employees (including nonemployee staff),						
	with special emphasis placed on carrying out						
	the procedures necessary to protect patients						
	and others.						
	(v) Maintain docui	mentation of all emergency					
preparedness training		1					

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i i i i i i i i i i i i i i i i i i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	.ETED
		155654	B. W	NG		08/03	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			NGLE RD		
ENGLEV	OOD HEALTH & F	REHABILITATION CENTER			VAYNE, IN 46809		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ' '	ncy preparedness policies					
		re significantly updated, the					
	updated policies a	duct training on the					
	procedures.	ind					
	procedures.						
	*[For PRTFs at §441.184(d):] (1) Training						
	program. The PRTF must do all of the						
	following:						
	(i) Initial training ir	n emergency preparedness					
	policies and procedures to all new and						
	existing staff, individuals providing services						
		nt, and volunteers,					
		eir expected roles.					
	1 ' '	ning, provide emergency					
	1 ' '	ning every 2 years.					
	1 ' '	staff knowledge of					
	emergency proce						
		mentation of all emergency					
	preparedness trai	· ·					
	. ,	cy preparedness policies					
	· ·	re significantly updated, the					
	policies and proce	uct training on the updated					
	policies and proce	edules.					
	*[For PACE at §46	60.84(d):] (1) The PACE					
	organization must	do all of the following:					
	(i) Initial training ir	n emergency preparedness					
	policies and proce	edures to all new and					
	existing staff, indiv	viduals providing on-site					
		rangement, contractors,					
		olunteers, consistent with					
	their expected roles.						
	(ii) Provide emergency preparedness training						
	at least every 2 years.						
	(iii) Demonstrate staff knowledge of						
	emergency procedures, including informing						
	· ·	at to do, where to go, and					
	whom to contact in case of an emergency.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		A. BUILDING B. WING		INSTRUCTION	COMPLETED 08/03/2023		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		2237 EN	ADDRESS, CITY, STATE, ZIP COD NGLE RD VAYNE, IN 46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	(v) If the emerger and procedures are PACE must condupolicies and procedures are Face and procedures and proced	re significantly updated, the act training on the updated edures. Is at §483.73(d):] (1) The LTC facility must do all a emergency preparedness edures to all new and viduals providing services and, and volunteers, eir expected role. Hency preparedness training ementation of all emergency pring. Is aff knowledge of dures. H85.68(d):](1) Training. The of the following: raining in emergency cies and procedures to all estaff, individuals providing rangement, and volunteers, eir expected roles. Hency preparedness training rangement, and volunteers, eir expected roles. Hency preparedness training rangement ency preparedness training rangement. Hency preparedness training rangement ency preparedness training rangement.		TAG			DATE
	systems and signal equipment.	ocation and use of alarm als and firefighting ncy preparedness policies					

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STATEMENT OF DEFICIENCIES X1) F		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL		
		155654	B. WI	NG		08/03/	/2023	
NAME OF I	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD			
					NGLE RD			
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER		FORT	VAYNE, IN 46809			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		re significantly updated, the		TAG	DEFICIENCE		DATE	
		uct training on the updated						
	policies and proce	- ·						
	*[For CAHs at §48	85.625(d):] (1) Training						
	1 ' -	H must do all of the						
	following:							
	· · /	n emergency preparedness edures, including prompt						
		nguishing of fires,						
		here necessary, evacuation						
	of patients, personnel, and guests, fire							
	prevention, and cooperation with firefighting							
		orities, to all new and						
	_	viduals providing services nt, and volunteers,						
	_	eir expected roles.						
		jency preparedness training						
	at least every 2 ye	· · · · · · · · · · · · · · · · · · ·						
	1 ' '	mentation of the training.						
	' '	staff knowledge of						
	emergency proce							
	. ,	ency preparedness policies re significantly updated, the						
	1	ct training on the updated						
	policies and proce	-						
		3485.920(d):] (1) Training.						
		provide initial training in						
		redness policies and new and existing staff,						
	1 '	ing services under						
	· ·	I volunteers, consistent with						
	their expected rol							
	documentation of the training. The CMHC							
		e staff knowledge of						
	emergency proce CMHC must prov	dures. Thereafter, the						
		ning at least every 2 years.						
	1	view and interview, the facility	E 00)37	E037 EP Training Program		08/16/2023	
	Based on record re-	view and interview, the facility	E 00)37	E037 EP Training Program		08/16/2023	

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/03/2023
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	2237	FADDRESS, CITY, STATE, ZIP COD ENGLE RD WAYNE, IN 46809	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DBE COMPLETION DATE
	knowledge of emer Preparedness Progr must do all of the fremergency prepare to all new and exist services under arrar consistent with their emergency prepare annually; (iii) Main emergency prepare Demonstrate staff k procedures in accord (1). This deficient presidents in the facility from the free procedures in accord (1) and the free procedures in the facility from the facility for the free procedures on 08/03/2 training conducted June 2023 did not he staff could demons Based on an intervireview, the Mainter of testing was proven the finding was reconstructed.	cnowledge of emergency rdance with 42 CFR 483.73(d) practice could affect all		1. What corrective act will be accomplished for residents found to have to affected by the deficient practice? At the time the deficiency videntified, no residents we to have been affected by the deficient practice. 2. How other residents having the potential to be affected by the same defipractice will be identified what corrective action(s) be taken? All residents had the potential to be affected by the deficient practice and all staff in the had the potential to be affected. 3. What measures will put into place or what systemages will be made to ensure that deficient practice and recur? Maintenance director immonducted tests for employensure that staff could demonstrate knowledge of EPP. Maintenance Director/designee will implementations.	was re found he secient and will htial to tf facility ected, nt was be stemic ctice ediately yees to f the

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/03/2023				
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				the "Emergency Preparednes Regulation" course through or Relias training/testing program employees to demonstrate knowledge of EPP annually. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed.	ur n for		
				Relias "Emergency Preparedr Regulation" course must be passed by each employee annually. New hires will be required to complete course d orientation process.			
E 0039 SS=F Bldg	441.184(d)(2), 482.483.73(d)(2), 484.485.68(d)(2), 485.486.360(d)(2), 49.EP Testing Requires \$416.54(d)(2), \$4.5460.84(d)(2), \$4.5460.84(d	18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)					

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		IDENTIFICATION NUMBER 155654	 UILDING	NSTRUCTION	COMPL 08/03/	ETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	2237 EN	ADDRESS, CITY, STATE, ZIP COD NGLE RD VAYNE, IN 46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		ne emergency plan ility] must do all of the				
	community-based (A) When a commot accessible, confunctional exercise (B) If the [facinatural or man-manactivation of the elis exempt from encommunity-based functional exercise actual event. (ii) Conduct an adevery 2 years, oppor functional exercional ex	nunity-based exercise is induct a facility-based every 2 years; or lity] experiences an actual ide emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based e following the onset of the ditional exercise at least posite the year the full-scale place is conducted, that may limited to the following: scale exercise that is or individual, facility-based exercise or workshop that is and includes a group in narrated, emergency scenario, and a tements, directed pared questions designed				
	, ,	418.113(d):] spices that provide care in e. The hospice must				

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Facility ID: 000498

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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		A. BUILDING B. WING			COMPLETED 08/03/2023		
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		2237 EN	ADDRESS, CITY, STATE, ZIP COD NGLE RD VAYNE, IN 46809		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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
	plan at least annument the following: (i) Participate in a community based (A) When a commaccessible, conduct based functional et (B) If the hospice of man-made emerged of the emergency exempt from engascale community-facility-based functional exercise of the emergency (ii) Conduct an act years, opposite the functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disasti (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem stamessages, or prepto challenge an error (3) Testing for hospicate directly. The exercises to test the per year. The hospication is community-facility and that is community-facility and that is community-facility and that is community-facility and the problem is a that is community-facility and the problem is a that is community-facility.	unity based exercise is not ct an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is ging in its next required full based exercise or individual tional exercise following the gency event. Iditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: scale exercise that is or a facility based e; or er drill; or ercise or workshop that is and includes a group in narrated, emergency scenario, and a tements, directed cared questions designed mergency plan. Spices that provide inpatient hospice must conduct exercise must do the following: in annual full-scale exercise					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		l í	UILDING	NSTRUCTION	COM	re survey ipleted)3/2023			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION D BE OPRIATE	(X5) COMPLETION DATE		
	(B) If the hospice man-made emergory of the emergency exempt from engatull-scale community functional exercise emergency event. (ii) Conduct an act that may include, following: (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop ext facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the hospice's emergency exercises, and enthe hospice's emergency exercises, and enthe hospice's emergency plan. (2) Testing. The [I conduct exercises plan twice per year CAH] must do the (i) Participate in a that is community (A) When a communicaccessible, conducted facility-based functions.	dditional annual exercise but is not limited to the scale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem ted messages, or prepared ed to challenge an sospice's response to and intation of all drills, tabletop inergency events and revise ergency plan, as needed. 441.184(d), Hospitals at as at §485.625(d):] PRTF, Hospital, CAH] must as to test the emergency ar. The [PRTF, Hospital, ar following: an annual full-scale exercise							

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Facility ID: 000498

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/03/2023				
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	that requires activ plan, the [facility] i its next required for individual, facility following the onse (ii) Conduct a exercise or and the limited to the follow (A) A second full-community-based facility-based function (B) A monomore (C) A tabletop is led by a facilitate discussion, using clinically-relevant set of problem state messages, or prepto challenge an erection (iii) Analyze the and maintain docutabletop exercises and revise the [fact and revise the [fact and maintain docutabletop exercises plan at least annuorganization must (i) Participate in a that is community (A) When a community (A) When a community-based function (B) If the PACE experies or man-made emergence activation of the exercises or and the packet of the pac	scale exercise that is or individual, a tional exercise; or ck disaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed oared questions designed mergency plan. ne [facility's] response to umentation of all drills, a, and emergency events cility's] emergency plan, as 50.84(d):] ACE organization must to test the emergency ally. The PACE do the following: un annual full-scale exercise abased; or unity-based exercise is not ct an annual individual,						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155654	B. W	ING		08/03/	2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	-ROVIDER OR SUFFLIER			2237 EN	NGLE RD		
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER		FORT V	VAYNE, IN 46809		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nity based or individual,					
	-	ctional exercise following the					
	onset of the emer						
	, ,	nn additional exercise every					
		the year the full-scale or					
		e under paragraph (d)(2)(i)					
	but is not limited t	conducted that may include,					
		-scale exercise that is					
	, ,						
	community-based or individual, a facility based functional exercise; or						
	(B) A mock disaster drill; or						
	(C) A tabletop exercise or workshop that is						
	led by a facilitator and includes a group						
	discussion, using a narrated,						
	_	emergency scenario, and a					
	set of problem sta						
	-	pared questions designed					
	to challenge an er	mergency plan.					
	(iii) Analyze the F	PACE's response to and					
	maintain docume	ntation of all drills, tabletop					
	exercises, and en	nergency events and revise					
	the PACE's emer	gency plan, as needed.					
	*[For LTC Facilitie	es at \$483.73(d):1					
	_	ity] must conduct exercises					
		ency plan at least twice per					
		announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	-					
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	(A) When a comm	nunity-based exercise is not					
		ıct an annual individual,					
	facility-based fund	ctional exercise.					
	(B) If the [LTC facility] facility experiences an						
	actual natural or r	nan-made emergency that					
		n of the emergency plan, the					
	_	mpt from engaging its next					
	required a full-sca	ale community-based or					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		155654	B. W	ING		08/03/	/2023
NAME OF F	PROVIDER OR SUPPLIEF	}		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					NGLE RD		
ENGLEV	ENGLEWOOD HEALTH & REHABILITATION CENTER			FORT V	VAYNE, IN 46809		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		based functional exercise					
	_	et of the emergency event.					
	' '	dditional annual exercise					
	_	but is not limited to the					
	following:						
		scale exercise that is					
	based functional e	or an individual, facility					
		•					
	(B) A mock disas						
	(C) A tabletop exercise or workshop that is led by a facilitator includes a group						
	discussion, using a narrated,						
	clinically-relevant emergency scenario, and a						
	set of problem statements, directed						
	3	pared questions designed					
	to challenge an er						
		LTC facility] facility's					
		naintain documentation of					
		exercises, and emergency					
	·	e the [LTC facility] facility's					
	emergency plan, a						
	*[For ICF/IIDs at §	• • •					
		CF/IID must conduct					
		he emergency plan at least					
		e ICF/IID must do the					
	following:						
		n annual full-scale exercise					
	that is community	•					
	' '	nunity-based exercise is not					
		ict an annual individual,					
		ctional exercise; or.					
	' '	experiences an actual					
		ade emergency that requires					
		mergency plan, the ICF/IID					
	•	igaging in its next required					
	full-scale community-based or individual, facility-based functional exercise following the						
		_					
	onset of the emer	ditional annual exercise					
	r (ii) Conduct an ad	ullional amilial exercise					I

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		A. BUILDING B. WING		COMPLETED 08/03/2023			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD NGLE RD		
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER			VAYNE, IN 46809		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
1710		but is not limited to the		1110			DITTE
	following:						
	_	scale exercise that is					
	community-based						
		ctional exercise; or					
	(B) A mock disast						
	, ,	ercise or workshop that is					
	, ,	and includes a group					
	discussion, using	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem statements, directed						
messages, or prepared questions designed							
to challenge an emergency plan.							
	(iii) Analyze the ICF/IID's response to and						
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events, and revise					
	the ICF/IID's eme	rgency plan, as needed.					
	*[For HHAs at §48	34.102]					
	(d)(2) Testing. The	e HHA must conduct					
	exercises to test t	he emergency plan at					
	least annually. Th	e HHA must do the					
	following:						
		full-scale exercise that is					
	community-based						
	1 ' '	ommunity-based exercise					
	· ·	conduct an annual					
	_	based functional exercise					
	every 2 years; or.						
	, ,	A experiences an actual					
		ade emergency that requires					
		mergency plan, the HHA is					
		aging in its next required					
		nity-based or individual,					
	1	tional exercise following the					
	onset of the emer						
	` '	ditional exercise every 2					
		e year the full-scale or					
	of this section is c	e under paragraph (d)(2)(i) conducted, that may					
	1 01 1113 36011011 18 0	onductou, that may	1				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155654		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/03/2023				
		ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ATE	(X5) COMPLETION DATE	
		(A) A second community-based facility-based function (B) A mock di (C) A tableton is led by a facilitat discussion, using clinically-relevant set of problem state messages, or prepto challenge an er (iii) Analyze the Himaintain documer exercises, and enterexercises, and enterexercises to test the HHA's emergent or workshop at lease exercise is led by group discussion, relevant emergency plan. I actual natural or not required testing exercises, and enterexercises activation opposite of the emergency (ii) Analyze the Ofmaintain documer exercises, and enterexercises, and enterexercises, and enterexercises, and enterexercises, and enterexercises, and enterexercises, and enterexercises.	stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop mergency events, and revise ency plan, as needed. 36.360] Be OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cry scenario, and a set of its, directed messages, or its designed to challenge and the OPO experiences and man-made emergency plan, the orm engaging in its next exercise following the onset						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		155654	B. WI	NG		08/03/	/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	X		2237 E	NGLE RD		
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER		FORT \	WAYNE, IN 46809		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	*[RNCHIs at §403						
		e RNHCI must conduct					
	RNHCI must do the	he emergency plan. The					
		er-based, tabletop exercise					
		A tabletop exercise is a					
		led by a facilitator, using a					
		/-relevant emergency					
		et of problem statements,					
		es, or prepared questions					
		enge an emergency plan.					
	(ii) Analyze the RNHCI's response to and						
	` '	ntation of all tabletop					
	exercises, and en	nergency events, and revise					
		rgency plan, as needed.					
	Based on record rev	view and interview, the facility	E 00)39	E039 EP Testing Requiremen	nts	08/18/2023
	failed to conduct ex	xercises to test the emergency			Plan of Correction		
	plan at least twice p	_					
		drills using the emergency					
	-	TC facility must do the			1. What corrective action(
	following:				will be accomplished for tho		
		annual full-scale exercise that			residents found to have been affected by the deficient		
	is community-based						
		ity-based exercise is not			practice?		
		an annual individual,					
	facility-based funct				At the time the deficiency was		
		ty experiences an actual natural			identified, no residents were fo	ouna	
		gency that requires activation lan, the LTC facility is exempt			to have been affected by the		
		next required full-scale in a			deficient practice.		
		or individual, facility-based			2. How other residents		
	_	l exercise for 1 year following			having the potential to be		
	the onset of the acti	-			affected by the same deficie	nt	
		litional exercise that may			practice will be identified and		
	` ′	imited to the following:			what corrective action(s) wil		
	a. A second full-sca	_			be taken?	-	
		or an individual, facility-based					
	functional exercise.	-			All residents had the potential	to	
	b. A mock disaster	drill; or			be affected by the deficient		
		ise or workshop that is led by a			practice and all staff in the fac	ility	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/03/2023	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	2237 EI	ADDRESS, CITY, STATE, ZIP COD NGLE RD NAYNE, IN 46809	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facilitator that inclu a narrated, clinically and a set of problen messages, or prepar challenge an emerg (iii) Analyze the LT maintain documenta exercises, and emer LTC facility's emer accordance with 42 deficient practice co Findings include: Based on records re Director on 08/03/2 documentation for a no documentation of choice was availabl interview at the tim Maintenance Direct choice was not cond This finding was re-	des a group discussion, using y-relevant emergency scenario, n statements, directed ed questions designed to		had the potential to be affected but no employee or resident was affected. 3. What measures will be put into place or what system changes will be made to ensure that deficient practice does not recur? Tabletop exercise is schedule all department heads on 8/17/which will be led by Maintenar Director that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed message and prepared questions desig to challenge our Active Shoote emergency plan. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed. Maintenance director/designed ensure the facility maintains training compliance with two scheduled Emergency	nic e d for 2023 nice ns, ned er
				Preparedness testing requirements annually.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/03/2023		
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809					
(X4) ID PREFIX TAG K 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 08/03 Facility Number: 0 Provider Number: 1002 At this Life Safety O Health & Rehabilita compliance with Re Medicare/Medicaid Life Safety From Fi National Fire Protec Life Safety Code (L Health Care Occupa This one story facilit Type V (111) const: The facility has a fir detection in the corr corridor and has har resident sleeping ro capacity of 67 and h of this visit. All areas where resi were sprinklered. A	200498 155654 266110 Code survey, Englewood ation Center was found not in equirements for Participation 42 CFR Subpart 483.90(a), re and the 2012 Edition of the etion Association (NFPA) 101, 2SC), Chapter 19, Existing ancies and 410 IAC 16.2. Aty was determined to be of ruction and fully sprinklered, re alarm system with smoke ridors, in all areas open to the red wired smoke detectors in all oms. The facility has a mad a census of 50 at the time dents have customary access all areas providing facility dered except for three ildings.	K 00	000	The following plan of correction constitutes our written allegation of compliance for the deficient cited. Submission of this plan correction is not an admission the deficiency exists or that or was cited correctly. This plan correction is submitted to meet the requirements established State and Federal law. This facility respectfully reques paper compliance for the deficiencies cited.	ion cies n of n that ne of et by		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/03/2023			
	PROVIDER OR SUPPLIER	EEHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
K 0363	NFPA 101		1110		52		
SS=D	Corridor - Doors						
Bldg. 01	Corridor - Doors						
Diag. 01	-	corridor openings in other					
		osures of vertical openings,					
	-	s areas resist the passage					
		made of 1 3/4 inch					
		wood or other material					
		ig fire for at least 20					
	-	fully sprinklered smoke					
	compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching						
	hardware. Roller la	atches are prohibited by					
	CMS regulation. T	hese requirements do not					
	apply to auxiliary s	spaces that do not contain					
	flammable or com	bustible material.					
	Clearance betwee	n bottom of door and floor					
	-	ceeding 1 inch. Powered					
		vith 7.2.1.9 are permissible					
	-	device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
		rs. Hold open devices that					
		door is pushed or pulled are					
	-	ed protective plates of					
		re permitted. Dutch doors					
		3 are permitted. Door					
		beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	fire window assemblies are					
	•	n sprinklered compartments					
	-	ctions in area or fire					
		s or frames in window					
	assemblies.	S OF HAIRIOS III WINDOW					
	19.3.6.3, 42 CFR I 483, and 485	Parts 403, 418, 460, 482,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155654 B. WING 08/03/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2237 ENGLE RD **ENGLEWOOD HEALTH & REHABILITATION CENTER** FORT WAYNE, IN 46809 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility K 0363 08/16/2023 **K363 Corridor - Doors** failed to ensure 1 of 9 resident room doors on the Plan of Correction 200-hall resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect 2 residents in room What corrective action(s) will be accomplished for those residents found to have been Findings include: affected by the deficient practice? Based on observation with the Maintenance Director on 08/03/23 at 10:20 a.m. resident room At the time the deficiency was corridor door 212 had up to a ½ inch gap between identified, no residents were found the top of the door and the door frame. Based on to have been affected by the interview at the time of observation, the deficient practice. Maintenance Director agreed there was a ½ inch gap between the top of the door and the door How other residents frame. having the potential to be affected by the same deficient The finding was reviewed with the Administrator practice will be identified and and the Maintenance Director during the exit what corrective action(s) will conference. be taken? 3.1-19(b) Two residents had the potential to have been affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?

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The door frame and top hinge were adjusted to lessen the ½ inch gap between the top of the door and the door frame. The Maintenance Director also put foam on the door

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		A. BUILDING B. WING	01	COMPLETED 08/03/2023
NAME OF PROVIDER OR SUP	LIER & REHABILITATION CENTER	2237 E	ADDRESS, CITY, STATE, ZIP COD NGLE RD WAYNE, IN 46809	
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIE CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
complies with Code, electric complies with Code. Existing service provided 18.5.1.1, 19.5 Based on observice provided 19.5.1.1, 19.5 Based on observice box. LSC 9.1. equipment to be Electrical Code shall be made in deficient practification of the Findings included 19.5 Based on observice provided	and Electric ing gas or related gas piping NFPA 54, National Fuel Gas al wiring and equipment NFPA 70, National Electric g installations can continue in ed no hazard to life. 1.1, 9.1.1, 9.1.2 vation, the facility failed to ensure I splices were made in a junction requires electrical wiring and comply with NFPA 70, National 1. Article 322.56 (A) states splices in listed junction boxes. This ice could affect 8 residents in the e 300-hall.	K 0511	to ensure there is no gap between the door and door frame. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed. Maintenance director audited all doors to ensure the no gap between the door and frame. All doors are in complia with regulation. K511 – Utilities – Gas and Electric Plan of Correction 1. What corrective action(will be accomplished for the residents found to have been affected by the deficient practice? At the time the deficiency was	rere is door ance 08/16/2023

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155654		UILDING	onstruction 01	(X3) DATE COMPL 08/03/	ETED
	PROVIDER OR SUPPLIED	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	Director on 08/03/2 above the ceiling ti were electrical splic ceiling that were no box. Based on inter observations, the M acknowledged ther were not protected This finding was re	23 at 11:45 a.m. in the breakroom les by the attic hatch there ced wires hanging out of the ot contained inside a junction view at the time of the laintenance Director e were electrical splices that with a junction box. viewed with the Administrator birector during the exit		TAG	identified, no residents were f to have been affected by the deficient practice. 2. How other residents having the potential to be affected by the same deficie practice will be identified an what corrective action(s) wil be taken? Eight residents had the poten to be affected by the deficient practice. 3. What measures will be put into place or what syste changes will be made to ensure that deficient practic does not recur? Maintenance Director installed junction box cover and fire ca around the cover to ensure the were no gaps.	nt d l tial e	DATE
					4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed. All electrical spliced wires are safely contained inside of a junction box.	•	

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	PROVIDER OR SUPPLIER VOOD HEALTH & REHABILITATION CENTER	2237 E	ADDRESS, CITY, STATE, ZIP COD NGLE RD WAYNE, IN 46809		
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained for 2 of 2 electrical panels in the Fire Control Panel (FCP) mechanical room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be	K 0911	K911 Electrical Systems - Oth Plan of Correction 1. What corrective action(swill be accomplished for those residents found to have been affected by the deficient practice? At the time the deficiency was identified, no residents were for to have been affected by the deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The deficient practice had the potential to affect the 30 reside in the 100 and 200 halls.	ner 08/18/2023	
	clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B)		3. What measures will be put into place or what system changes will be made to	nic	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155654	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 08/03/2023		
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION DATE		
	shall not be used for practice could affect 200 halls. Findings include: Based on observation with the Maintenant 10:41 a.m., the two mechanical room wand tool cart and other panels. Based on ir observations, the Mitems were stored was front of the electrical.	pace required by this section restorage. This deficient it 30 residents in the 100 and ons during a tour of the facility one Director on 08/04/23 at electrical panels in the FCP ere blocked from access with the resternier at the time of the aintenance Director agreed within the working space in all panels.		ensure that deficient pradoes not recur? Items were removed from mechanical room to allow pathway to access the elepanels. 4. How will the correct action(s) be monitored to ensure the deficient praction will not recur? ie: what QA program will put into place and by who date will they be completed. The supplies will no longer stored in mechanical room	the a clear ectrical tive ctice I be at ted.		
K 0923 SS=E Bldg. 01	Storag	Cylinder and Container Cylinder and Container		ensure there is a clear pa electrical panels.	thway to		
	Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or within space of non- or liconstruction, with that can be secure stored with flammar.	qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 subic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and outdoors outdoors) and outdoors outdoors outdoors ables, and are separated as by 20 feet (5 feet if					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED	
155654			B. WING	08/03/2023		
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	sprinklered) or en	closed in a cabinet of				
	noncombustible construction having a					
	minimum 1/2 hr. fire protection rating.					
	Less than or equal to 300 cubic feet					
	In a single smoke compartment, individual					
	cylinders available for immediate use in					
	patient care areas with an aggregate volume					
	of less than or equal to 300 cubic feet are not					
	required to be stored in an enclosure.					
	Cylinders must be handled with precautions					
	as specified in 11.6.2.					
	A precautionary sign readable from 5 feet is					
	on each door or gate of a cylinder storage					
	room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)					
		` ,				
	STORED WITHIN					
		d so cylinders are used in				
	order of which they are received from the					
	supplier. Empty cylinders are segregated from full cylinders. When facility employs					
	_	gral pressure gauge, a				
		e considered empty is				
	· ·	oty cylinders are marked to				
		Cylinders are marked to				
	are protected from	· ·				
	-	.3.3, 11.3.4, 11.6.5 (NFPA				
	99)	,, (1117)				
		on and interview, the facility	K 0923	K923 – Gas Equipment –	08/18/2023	
		ninimum distance of at least five	11 0) 2 3	Cylinder and Container	00/10/2025	
		oustible materials from oxygen		Storage		
	•	in 1 of 1 oxygen trans-filling		Plan of Correction		
		1.3.2.3 requires oxidizing gases				
		ll be separated from				
		e of the following: (1) a		1. What corrective action	(s)	
	_	of 20 feet. (2) a minimum		will be accomplished for the	` '	
	distance of 5 feet if the required storage location is protected by an automatic sprinkler system in			residents found to have bee		
				affected by the deficient		
accordance with NFPA 13, Standard for the			practice?			
	Installation of Sprin	nkler Systems. (3) Enclosed				
	_	oustible construction having a		At the time the deficiency was		

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		IDENTIFICATION NUMBER 155654	A. BUILDING B. WING	01	COMPLETED 08/03/2023	
NAME OF PROVIDER OR SUPPLIER ENGLEWOOD HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2237 ENGLE RD FORT WAYNE, IN 46809			
(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 PREFIX (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	minimum fire protect deficient practice cosmoke compartment. Findings include: Based on observation facility with the Marat 10:30 a.m., three five feet of stationar the oxygen storage at on interview at the the Maintenance Direct shelving was within oxygen containers. The finding was rev	LSC IDENTIFYING INFORMATION ction rating of ½ hour. This ould affect 20 residents in one		identified, no residents were for to have been affected by the deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? The deficient practice had the potential to affect 20 residents one smoke compartment. 3. What measures will be put into place or what system changes will be made to ensure that deficient practice does not recur? The three wooden shelves we removed, and metal shelves we installed as non-combustible shelves.	nt d l l l l l l l l l l l l l l l l l l	
				action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed. Noncombustible items will no longer be stored in oxygen storoom.		

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