ENTERS FOR	MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938	3-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155249	B. WING		11/10/2022	
NAME OF P	ROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP COD		
				RANDY CHASE COVE		
CHATEA	U REHABILITATIO	ON AND HEALTHCARE CENTER	FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5	5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLE	TION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DAT	E
0000						
Dida						
Bldg	An Emergency Dr	eparedness Survey was	E 0000	This Plan of Correction is t	ha	
		ndiana Department of Health in	E 0000	center's credible allegation		
	accordance with 4	-		compliance.		
		2 011 103.75.		Preparation and/or executi	on of	
	Survey Date: 11/1	0/22		this plan of correction does constitute admission or ag	s not	
	Facility Number: (000153		by the provider of the truth		
	Provider Number:			facts alleged or conclusion		
	AIM Number: 100	266910		forth in the statement of		
				deficiencies. The plan of		
	At this Emergency	Preparedness survey, Chateau		correction is prepared and	/or	
		Iealthcare was found in		executed solely because it	is	
	-	ance with Emergency		required by the provisions	of	
		airements for Medicare and		federal and state law.		
	-	ting Providers and Suppliers, 42				
		facility has a capacity of 99 and				
	liad a cellsus of 89	at the time of this survey.				
	Quality Review or	n 11/17/22				
0023		l6.54(b)(4), 418.113(b)(3),				
SS=C		32.15(b)(5), 483.475(b)(5),				
Bldg		4.102(b)(4), 485.625(b)(5),				
		5.727(b)(3), 485.920(b)(4),				
	Policies/Procedu	91.12(b)(3), 494.62(b)(4)				
	Documentation					
		§416.54(b)(4), §418.113(b)				
		5), §460.84(b)(6), §482.15(b)				
), §483.475(b)(5),				
		§485.68(b)(3), §485.625(b)				
		3), §485.920(b)(4),				
	§486.360(b)(2), §	491.12(b)(3), §494.62(b)(4).				
	,	procedures. The [facilities]				
	must develop an	d implement emergency				
ABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DAT	ГЕ
	ntoski		Es sility (Administrator	11/28/20	100

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. PRINTED:

11/30/2022

	CORRECTION	IDENTIFICATION NUMBER 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING CERFET ADDRESS CITY STATE ZID COD		(X3) DATE SURVEY COMPLETED 11/10/2022	
NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER		6006 E	TADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLET DATE
	on the emergence (a) of this section paragraph (a)(1) communication p section. The politic be reviewed and years [annually for minimum, the politic address the follow [(5) or (3),(4),(6)] documentation the information, protection information, and a availability of recommendation (i) Preserves path (ii) Protects confli- nformation. (iii) Secures and records. *[For OPOs at §4 procedures. (2) a documentation the actual donor infor confidentiality of information, and availability of recommendation confidentiality of actual donor infor confidentiality of actual donor record re- failed to ensure em- and procedures inco- documentation that actual donor infor confidentiality of recommendation availability of recommendation that actual donor infor confidentiality of recommendation that actual donor infor confidential that actual donor infor	A system of medical at preserves patient ects confidentiality of patient secures and maintains ords. §403.748(b):] Policies and a system of care at does the following: ent information. dentiality of patient maintains the availability of 86.360(b):] Policies and A system of medical at preserves potential and mation, protects potential and actual donor secures and maintains the	E 0023	E023 Policy/Procedures fo Medical Documentation The facility requests paper compliance for this citation This Plan of Correction is	n.	11/30/20

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155249	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/10/2022	
NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER		6006 B	STREET ADDRESS, CITY, STATE, ZIP COD 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CTION (X5 ULD BE PROPRIATE DATE	
	 483.73(b)(4). This occupants. Findings include: Based on record re Assistant, U.P. Ma Administrator on 1 provided Emergen not contain docum system to preserve documentation dur interview at the tin and the Administrator system to preserve documentation was The finding was re Assistant, U.P. Ma Administrator, and 	deficient practice could affect all view with the Maintenance intenance Director, DON, and 1/10/22 at 10:35 a.m., the cy Preparedness Plan (EPP) did entation to indicate the use of a resident medical ing an emergency. Based on ne of record review, the DON ator stated the policy on a resident medical		Preparation and/or exe this plan of correction constitute admission of agreement by the prove the truth of the facts all conclusions set forth it statement of deficienci- plan of correction is pr and/or executed solely it is required by the pro- of federal and state law 1)Immediate actions tal those residents identifi No resident was found affected by the finding. 2)How the facility idents other residents: All residents that reside community have the po- to be affected by the all deficient practice 3) Measures put into pl System changes: Facility has reviewed a updated its Emergency Preparedness Plan to in facility assessment pol indicating continuity of operations related to M Documentation. Communication of upd have been completed w Staff and any other par IDT determines to be necessary. 4)How the corrective ad will be monitored: The Maintenance Director/designee will p	cution of does not r ider of leged or n the es. The epared because ovisions /. ken for ed to be ified e at the otential leged ace/ nd , nclude a icy edical ates with ties the ctions	

	R MEDICARE & MEDI				ONGEDICETION		AB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				` '	E SURVEY LETED
ANDILAN	OF CORRECTION	155249		WING)/2022
				OTDEET			
NAME OF I	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP COD		
CHATEA	U REHABILITATIO	ON AND HEALTHCARE CENTER	र		WAYNE, IN 46815		
-	-		· 		1		(1/5)
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	ON D BE	(X5) COMPLETION
TAG		PR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
					Plan monthly to the QAP		
					Committee during QAPI		
					Meetings to ensure comp	letion	
					of any new necessary up		
					and compliance. The repo		
					will be reviewed in Qualit	-	
					Assurance Meeting mont 6 months or until 100%	nly for	
					compliance is achieved.	Tho	
					QA Committee will identi		
					trends or patterns and ma		
					recommendations to revi	se the	
					plan of correction as indi	cated.	
					5) Date of compliance:		
					11/30/2022		
E 0041	482.15(e), 483.7	3(e), 485.625(e)					
SS=C	Hospital CAH an	d LTC Emergency Power					
Bldg	,	ition for Participation:					
		nd standby power systems.					
		t implement emergency and					
		ystems based on the					
	• • •	set forth in paragraph (a) of n the policies and					
		set forth in paragraphs (b)(1)					
	(i) and (ii) of this						
	§483.73(e), §485	5.625(e)					
		nd standby power systems.					
		and the CAH] must					
		gency and standby power					
		n the emergency plan set h (a) of this section.					
	iorun in paragrap						
	\$482,15(e)(1) \$4	483.73(e)(1), §485.625(e)(1)					
		rator location. The					
		e located in accordance with					
	-	irements found in the Health			1		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	A.	MULTIPLE CO BUILDING WING	DNSTRUCTION		(X3) DATE SURVEY COMPLETED 11/10/2022	
	NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTE		2	6006 BI	ADDRESS, CITY, STATE, ZIP (RANDY CHASE COVE WAYNE, IN 46815	COD		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF COR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION CORRECTIVE ACTION CORRECTIVE ACTION FOR CORST.)				SHOULD BE	ГЕ	(X5) COMPLETION	
TAG	Interim Amendm 12-4, TIA 12-5, a Code (NFPA 10 ⁻⁷ Amendments TIA and TIA 12-4), at structure is built structure or build 482.15(e)(2), §44 Emergency gene The [hospital, CA implement the er inspection, testin requirements fou Facilities Code, 1 Code. 482.15(e)(3), §44 Emergency gene and LTC facilities source to power have a plan for h power systems of emergency, unle *[For hospitals at §483.73(g), and The standards in this section are a reference by the Federal Register 552(a) and 1 CF the material from You may inspect Information Reso Boulevard, Baltir Archives and Re	 B3.73(e)(2), §485.625(e)(2) B3.73(e)(2), §485.625(e)(2) Barator inspection and testing. AH and LTC facility] must mergency power system Bg, and [maintenance] Ind in the Health Care NFPA 110, and Life Safety B3.73(e)(3), §485.625(e)(3) B3.73(e)(3), §485.625(e)(3) B3.73(e)(3), §485.625(e)(3) Barator fuel. [Hospitals, CAHs Barator fuel. [Hospitals, CAHs Barator fuel maintain an onsite fuel emergency generators must now it will keep emergency perational during the 		TAG				DATE

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/10/2022	
	NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTEI		6006 B	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETI	
	_of_federal_regu If any changes in incorporated by r document in the announce the ch (1) National Fire Batterymarch Pa Quincy, MA 0216 1.617.770.3000. (i) NFPA 99, Hea 2012 edition, issu (ii) Technical inte NFPA 99, issued (iii) TIA 12-3 to N 2012. (iv) TIA 12-4 to N 2013. (v) TIA 12-5 to N 2013. (vi) TIA 12-5 to N 2013. (vi) TIA 12-6 to N 2014. (vii) NFPA 101, L edition, issued Ai (viii) NFPA 101, L edition, issued Ai (viii) TIA 12-1 to 1 11, 2011. (ix) TIA 12-2 to N 30, 2012. (x) TIA 12-3 to N 22, 2013. (xii) NFPA 110, 3 Standby Power S	Protection Association, 1 rk, 59, www.nfpa.org, alth Care Facilities Code, ued August 11, 2011. Frim amendment (TIA) 12-2 to August 11, 2011. IFPA 99, issued August 9, IFPA 99, issued March 7, FPA 99, issued August 1, IFPA 99, issued March 3, IFPA 99, issued March 3,				
	2009 Based on records 1 failed to implement	review and interview, the facility at the emergency power system d in the Health Care Facilities	E 0041	K041 Emergency and Powe Standby Systems The facility requests paper	r 11/30/20	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES I OF CORRECTION	x1) provider/supplier/clia identification number 155249	(X2) MULTIPLE CO A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 11/10/2022
	PROVIDER OR SUPPLIE	R DN AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815	
X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		and Life Safety Code in		compliance for this citation.	
		2 CFR 483.73(e)(2). This		This Plan of Correction is the	
	deficient practice of	could affect all occupants.		center's credible allegation of	
				compliance.	
	Findings include:			Preparation and/or execution of	
				this plan of correction does not	
		eview with the Maintenance		constitute admission or agreen	
		intenance Director, DON, and		by the provider of the truth of the	
		1/10/22 at 10:02 a.m., the		facts alleged or conclusions se	t
	-	nonthly, weekly, and yearly		forth in the statement of	
		LSC and NFPA 110. Based on		deficiencies. The plan of	
	ne of record review, the		correction is prepared and/or		
	missing some of the requ	ctor stated the generator was		executed solely because it is	
		e required testing.		required by the provisions of	
				federal and state law.	
	The finding was reviewed with the Maintenance			1)Immediate actions taken for	
		intenance Director, DON,		those residents identified	
		the Regional Director via		No resident was found to be	
	phone call during t	he exit conference.		affected by the finding.	
				2)How the facility identified oth	er
				residents:	
				Visitors, staff and residents that	
				reside at the community have t	ne
				potential to be affected by the	
				alleged deficient practice	
				3) Measures put into place/	
				System changes: a. 30 Minute Generator Load	
				Exercise has been completed	and
				is currently up to date.	
				b. Weekly Generator inspection	one
				are being completed and are	
				currently up to date.	
			c. Annual Load Bank Inspecti	on	
			has been completed and is		
				currently up to date.	
				d. 3-year 4 hour run under loa	ad
				has been completed and is	
				currently up to date.	
				e. Emergency Generator light	
	1		1	, <u> </u>	

	R MEDICARE & MEDI					IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE (A. BUILDING	(X3) DATE SURVEY COMPLETED		
	or conduction	155249	B. WING		11/10/	
			STDEET	TADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIE	ER		BRANDY CHASE COVE		
CHATEA		ON AND HEALTHCARE CENTER		WAYNE, IN 46815		
(X4) ID	SUDAMAD	STATEMENT OF DEFICIENCIE	ID	,		(V5)
PREFIX		EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
				testing has been completed a	Ind is	
				currently up to date.		
				4)How the corrective actions	will	
				be monitored:		
				The Maintenance		
				Director/designee will continu		
				conduct and schedule Genera	ator	
				Inspections accordingly.		
				Maintenance Director/designe		
				will bring inspections to Quali Assurance Meeting for 6 mon	-	
			The QA Committee will identi			
				any trends or patterns and ma	-	
				recommendations to revise th		
				plan of correction as indicated		
				5) Date of compliance:		
				11/30/2022		
K 0000						
Bldg. 01						
Didg. 01	A Life Safety Cod	e Recertification and State	K 0000	This Plan of Correction is the		
		was conducted by the Indiana	100000	center's credible allegation of		
	Department of He	alth in accordance with 42 CFR		compliance.		
	483.90(a).			Preparation and/or execution	of	
				this plan of correction does no		
	Survey Date: 11/2	10/22		constitute admission or agree		
	Equility Number	000153		by the provider of the truth of		
	Facility Number: Provider Number:			facts alleged or conclusions s forth in the statement of	el	
	AIM Number: 100			deficiencies. The plan of		
				correction is prepared and/or		
	At this Life Safety	v Code survey, Chateau		executed solely because it is		
		Healthcare was found not in		required by the provisions of		
	compliance with H	Requirements for Participation in		federal and state law.		
		d, 42 CFR Subpart 483.90(a),				
		Fire and the 2012 edition of the				
		ection Association (NFPA) 101,				
	Life Safety Code	(LSC), Chapter 19, Existing		1		

	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/10/2022	
	OVIDER OR SUPPLIE REHABILITATIO	R N AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815	-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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)	(X5) COMPLETIO DATE	
< 0211 SS=E Bldg. 01	This one story faci room was determin construction and w facility has a fire a detection in the co corridors and hard resident rooms. The Type II EES 350 k The facility has a co of 89 at the time o All areas providing residents were sprid detached garage ar facility services in equipment, new be maintenance suppl Quality Review or NFPA 101 Means of Egress Means of Egress Aisles, passagew discharges, exit I in accordance wi of egress is conti all obstructions to emergency, unle- through 18/19.2. ⁷ 18.2.1, 19.2.1, 7. Based on observat failed to maintain free of impedimen of fire or other em 7.1.10.1. LSC 7.2	g customary access to the nklered. The facility had a ad three sheds providing cluding storage of old eds, mattresses and ies that were not sprinklered. 11/17/22 - General - General yays, corridors, exit ocations, and accesses are th Chapter 7, and the means nuously maintained free of o full use in case of ss modified by 18/19.2.2	K 0211	K211 Quality Review Means Egress-General This Plan of Correction is th center's credible allegation compliance. Preparation and/or executio	e of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID 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 B. WING 11/10/2022 155249 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE CHATEAU REHABILITATION AND HEALTHCARE CENTER FORT WAYNE. IN 46815 (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 that a horizontal force not to exceed 15 lbf (66 N) constitute admission or actuates the cross bar or push pad and latches. agreement by the provider of This deficient practice could affect 20 residents in the truth of the facts alleged or one hall. conclusions set forth in the statement of deficiencies. The Findings include: plan of correction is prepared and/or executed solely because Based on observations with the Maintenance it is required by the provisions Assistant, U.P. Maintenance Director, DON, and of federal and state law. Administrator on 11/10/22 at 11:35 a.m., the exit door by the DON office was equipped with panic 1)Immediate actions taken for hardware, but the door would not open on the those residents identified first try. It took three tries to open the door taking No resident was found to be excessive force to open the door. Based on affected by the finding. interview at the time of observation, the Maintenance Assistant and the U.P. Maintenance 2)How the facility identified Director agreed it took excessive force to open the other residents: exit door due to the paint making the door stick. All residents that reside at the community have the potential The finding was reviewed with the Maintenance to be affected by the alleged Assistant, U.P. Maintenance Director, DON, deficient practice. Administrator, and the Regional Director via phone call during the exit conference. 3) Measures put into place/ System changes: 3.1-19(b) The exit door located by the DON office was evaluated and repaired to ensure proper opening and closing. 4)How the corrective actions will be monitored: Maintenance Director/Designee will audit 5 random exit doors weekly to ensure] the doors properly open and close. Maintenance Director/Designee will provide the findings of the audit to the QAA committee monthly for 6 months or when

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2U4G21

Facility ID: 000153

If continuation sheet

Page 10 of 43

11/30/2022

PRINTED:

FORM APPROVED

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IULTIPLE C	onstruction <u>01</u>		(X3) DATE SURVEY COMPLETED	
		155249	B. W	/ING		11/	10/2022	
	NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6006 BRANDY CHASE COVE TER FORT WAYNE, IN 46815					
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPH TAG DEFICIENCY)		OULD BE	(X5) COMPLETION DATE	
					100%compliance is ac	hieved.		
					5) Date of compliance 11/30/2022	:		
K 0222 SS=E Bldg. 01	be equipped with requires the use egress side unless special locking and CLINICAL NEED LOCKING Where special loc clinical security in used, only one loc permitted on eact be made for the in by: remote control locks or keys car other such reliab staff at all times. 18.2.2.2.5.1, 18.2 19.2.2.2.6 SPECIAL NEED ARRANGEMENT Where special loc safety needs of the the Clinical or Sec are being met. In electrical locks the release upon loss building is protect automatic sprinklispace is protected	S OR SECURITY THREAT cking arrangements for the eeds of the patient are cking device shall be h door and provisions shall rapid removal of occupants of of locks; keying of all ried by staff at all times; or le means available to the 2.2.2.6, 19.2.2.2.5.1, S LOCKING						

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155249	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	R ON AND HEALTHCARE CENTER	6006	r address, city, state, zip cod BRANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION the sprinkler and detection	TAG	DEFICIENCY	DATE	
	systems are arra upon activation. 18.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed systems installed 7.2.1.6.1 shall be assemblies servit contents in buildi an approved, sup detection system automatic sprinkl 18.2.2.2.4, 19.2.2 ACCESS-CONTE LOCKING ARRA Access-Controlle installed in accor be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOB LOCKING ARRA Elevator lobby ex accordance with on door assembli throughout by an automatic fire det approved, superv system. 18.2.2.2.4, 19.2.2 Based on observat failed to ensure the 2 exits with specia clinical security ne readily accessible carried by staff at a means available to	Anged to unlock the doors 2.2.2.5.2, TIA 12-4 ESS LOCKING S delayed-egress locking in accordance with permitted on door ang low and ordinary hazard angs protected throughout by ervised automatic fire or an approved, supervised er system. 2.2.4 ROLLED EGRESS NGEMENTS d Egress Door assemblies dance with 7.2.1.6.2 shall 2.2.4 BY EXIT ACCESS NGEMENTS it access door locking in 7.2.1.6.3 shall be permitted es in buildings protected approved, supervised ection system and an ised automatic sprinkler 2.2.4 on and interview, the facility means of egress through 1 of locking arrangements for the eds of the residents were by remote control of locks; keys and affect 25 residents in the	K 0222	K222: Egress Doors The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does no constitute admission or agree	ot	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 11/10/2022	
NAME OF PROVIDER OR SUPPLIER CHATEAU REHABILITATION AND HEALTHCARE CENTER		6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815			
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	Findings include: Based on observat Assistant, U.P. Ma Administrator on I Memory Care exit opened by entering had special locking with clinical secur the hall was asked person did not enter not open the door. of observation, the the code and the U agreed a staff perso code to open the ex- The finding was re Assistant, U.P. Ma Administrator, and	ion with the Maintenance intenance Director, DON, and 1/10/22 at 9:35 a.m., the door was locked, could be g a four-digit code, and the hall g arrangements for residents ity needs; but when a Nurse on to open the door, the staff er the correct code and could Based on interview at the time Nurse stated she did not know .P. Maintenance Director on on the hall did not know the		by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified oth residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. All exit doors have the key code posted at a visible level in the keypad. 4)How the corrective actions w be monitored: The Maintenance Director/designee has re-educa staff members of the location of the key codes. Maintenance Director/designee will audit all doorways to ensure codes are present and visible weekly for 0 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. QA Committee will identify any trends or patterns and make recommendations to revise the	er er at the lear fill ated of exit 6	

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 * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 3:00 p.m., in the upstairs mechanical room there were three attic hatch smoke doors that were open and not self-closing due to the springs to close the doors 		-	-			
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required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power.Koss of power.18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment.K 0223K223 Doors with Self-Closing Devices The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.11/30/20Findings include:Findings include:Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared			-			
 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment. Findings include: Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 3:00 p.m., in the upstairs mechanical room there were three attic hatch smoke doors that were open and not self-closing due to the springs to close the doors 		smoke passing th	rough the opening or a			
 * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 3:00 p.m., in the upstairs mechanical room there were three attic hatch smoke doors that were open and not self-closing due to the springs to close the doors 		required smoke of	letection system; and			
 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 3:00 p.m., in the upstairs mechanical room there were three attic hatch smoke doors that were open and not self-closing due to the springs to close the doors K 0223 K 023 K 0223 K 023 <		* Automatic sprin	kler system, if installed; and			
Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment.K 0223K223 Doors with Self-Closing Devices The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.11/30/20Findings include:Frindings include:Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared11/30/20		* Loss of power.				
failed to ensure 3 of 3 attic smoke hatch doorsDeviceswere self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment.The facility requests paper compliance for this citation.Bindings include:This Plan of Correction is the center's credible allegation of compliance.Findings include:Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared						
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unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment.compliance for this citation. This Plan of Correction is the center's credible allegation of compliance.Findings include:Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared						
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35 residents in one smoke compartment.center's credible allegation of compliance.Findings include:Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared					-	
Findings include:compliance.Findings include:Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared			-			
Findings include:Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared		35 residents in one	smoke compartment.		_	ŗ.
Based on observations with the Maintenancethis plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared		F' 1' ' 1 1			-	
Based on observations with the Maintenanceconstitute admission orAssistant, U.P. Maintenance Director, DON, andagreement by the provider ofAdministrator on 11/10/22 at 3:00 p.m., in thethe truth of the facts alleged orupstairs mechanical room there were three atticconclusions set forth in thehatch smoke doors that were open and notstatement of deficiencies. Theself-closing due to the springs to close the doorsplan of correction is prepared		Findings include:			-	
Assistant, U.P. Maintenance Director, DON, andagreement by the provider ofAdministrator on 11/10/22 at 3:00 p.m., in thethe truth of the facts alleged orupstairs mechanical room there were three atticconclusions set forth in thehatch smoke doors that were open and notstatement of deficiencies. Theself-closing due to the springs to close the doorsplan of correction is prepared		Based on charment	one with the Maintananas		-	στ
Administrator on 11/10/22 at 3:00 p.m., in the upstairs mechanical room there were three attic hatch smoke doors that were open and not self-closing due to the springs to close the doorsthe truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared						
upstairs mechanical room there were three attic hatch smoke doors that were open and not self-closing due to the springs to close the doorsconclusions set forth in the statement of deficiencies. The plan of correction is prepared						
hatch smoke doors that were open and notstatement of deficiencies. Theself-closing due to the springs to close the doorsplan of correction is prepared					-	"
self-closing due to the springs to close the doors plan of correction is prepared						
		-				
time of observation, the Maintenance Assistant <i>it is required by the provisions</i>					-	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction 01	(X3) DATE SURVEY COMPLETED
	of condition	155249	B. WING	<u>01</u>	11/10/2022
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	4
CHATE	AU REHABILITATIO	ON AND HEALTHCARE CENTER		WAYNE, IN 46815	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE COMPLET
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	tch smoke doors had the		of federal and state law.	
	self-closing device	e (the spring) disconnected.		1)Immediate actions taken for	or
				those residents identified	
	-	eviewed with the Maintenance		No resident was found to be)
		intenance Director, DON,		affected by the finding.	
		the Regional Director via		2)How the facility identified	
	phone call during	the exit conference.		other residents:	h.
	3.1-19(b)			All residents that reside at the	-
	5.1-19(0)			community have the potenti to be affected by the alleged	
				deficient practice	1
				3) Measures put into place/	
				System changes:	
				Maintenance Director has	
				corrected the springs to the	
				three attic hatch smoke doo	
				to allow for self-closing	
				4)How the corrective actions	5
				will be monitored:	
				The Maintenance	
				Director/designee will audit	the
				three attic hatch smoke doo	rs
				for proper mechanism and	
				closing weekly. Maintenan	ce
				Director/designee will prese	nt
				the audit monthly to the QA	PI
				Committee during QAPI	
				Meetings to ensure complet	ion
				of any new necessary updat	
				and compliance. The audit v	vill
				be reviewed in Quality	
				Assurance Meeting monthly	for
				6 months or until 100%	
				compliance is achieved. Th	
				QA Committee will identify a	-
				trends or patterns and make	
				recommendations to revise	
				plan of correction as indicat	ea.
				5) Date of compliance: 11/30/2022	
	1				

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155249	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	R DN AND HEALTHCARE CENTER	6006	r address, city, state, zip cod BRANDY CHASE COVE r WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY 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 APPROPRI/ DEFICIENCY)	ATE COMPLE DAT	ETIO
< 0324 SS=E Bldg. 01	accordance with Ventilation Contr Commercial Coo * residential cook appliances such toasters) are use cooking in accord 19.3.2.5.2 * cooking facilitie smoke compartm patients comply v 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer p conditions under Cooking facilities NFPA 96 per 9.2 enclosed as haza be open to the co 18.3.2.5.1 throug through 19.3.2.5. Based on record re interview; the facil kitchen fire suppre semiannually. NF for Ventilation Co Commercial Cook states Maintenanco systems and listed constant or fire-act listed to extinguish devices. Hood ext ducts shall be mad and certified perso having jurisdiction	ent is protected in NFPA 96, Standard for ol and Fire Protection of king Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited dance with 18.3.2.5.2, s open to the corridor in tents with 30 or fewer with the conditions under 2.5.3, or s in smoke compartments patients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to .3 are not required to be ardous areas, but shall not	K 0324	K324: Cooking Facilities The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of facts alleged or conclusions s forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	of ot ment the	/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/10/2022
	PROVIDER OR SUPPLIE	R DN AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE NCY 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 APPROPRI DEFICIENCY)	ATE (X5) COMPLETIC DATE
	therapy and the act Findings include: Based on observat Assistant, U.P. Ma Administrator on 1 p.m., the therapy g contained cooktop system. Based on 2:30 p.m., the only kitchen exhaust sy review was dated 1 interview at the tim observation, the U Administrator agre systems were last i stated when the ne they were unaware gym and the activi The finding was re Assistant, U.P. Ma Administrator, and	tivities room. tivities room. tivities room. tivities room. Director, DON, and 1/10/22 at 11:55 a.m. and at 2:30 ym and the activities room s with a fire-extinguishing records review at 11:55 a.m. and of documentation of semiannual stem inspection available for March of 2021. Based on ne of record review and P. Maintenance Director and the two fire-extinguishing inspected in March 2021 and w contractor stared in 2021 to of the systems in the therapy		required by the provisions of federal and state law. 1)Immediate actions taken fo those residents identified No resident was found to be affected by the finding. 2)How the facility identified of residents: Visitors, staff and residents the reside at the community have potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. Facility has ensured the cooktops with a fire extinguis system in the Physical Thera and Activities have a current inspection. 4)How the corrective actions be monitored: The Maintenance Director/designee will monito inspections moving forward. Maintenance Director/designed will bring current and future inspections to Quality Assura Meeting monthly for 6 months The QA Committee will identia any trends or patterns and m recommendations to revise th plan of correction as indicated 5) Date of compliance: 11/30/2022	r ther nat the the the the the the the the the th
0345 SS=F 3ldg. 01	NFPA 101 Fire Alarm System Maintenance Fire Alarm System	-			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2U4G21 Facility ID: 000153

If continuation sheet Page 17 of 43

PRINTED: 11/30/2022 FORM APPROVED

PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID 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 B. WING 11/10/2022 155249 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6006 BRANDY CHASE COVE CHATEAU REHABILITATION AND HEALTHCARE CENTER FORT WAYNE. IN 46815 (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 Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72.

FORM CMS-2567(02-99) Previous Versions Obsolete

etc.)

facility.

Findings include:

Assistant and the U.P. Maintenance Director on 11/10/22 at 9:35 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 01/07/22. Based on interview at the time of records review, the Maintenance Assistant and the U.P. Maintenance Director stated a visual inspection of the fire alarm

Sections 19.3.4.5.1 and 9.6. NFPA 72, Section

14.3.1 states that unless otherwise permitted by

14.3.2, visual inspections shall be performed in

more often if required by the authority having

a. Control unit trouble signals

b. Remote annunciators

d. Notification appliances

e. Magnetic hold-open devices

accordance with the schedules in Table 14.3.1, or

National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility K 0345 failed to maintain 1 of 1 fire alarm systems in K345 Fire Alarm Systemaccordance with NFPA 72, as required by LSC 101 **Testing and Maintenance**

must be visually inspected semi-annually: this plan of correction does not constitute admission or agreement by the provider of c. Initiating devices (e.g. duct detectors, manual the truth of the facts alleged or fire alarm boxes, heat detectors, smoke detectors, conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions

This deficient practice affects all occupants in the of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be

Event ID:

During records review with the Maintenance

The facility requests paper

compliance for this citation.

This Plan of Correction is the

center's credible allegation of

compliance. jurisdiction. Table 14.3.1 states that the following Preparation and/or execution of

> System changes: 2U4G21

Facility ID: 000153

affected by the finding.

other residents:

deficient practice

2)How the facility identified

All residents that reside at the

community have the potential

to be affected by the alleged

3) Measures put into place/

If continuation sheet

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11/30/2022 FORM APPROVED

11/30/2022

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	. ,	LETED
		155249	B. WING	<u></u>	- 1)/2022
			STREET	ADDRESS, CITY, STATE, ZIP CO	DD	
	PROVIDER OR SUPPLIE			RANDY CHASE COVE		
CHATE	U REHABILITATIO	ON AND HEALTHCARE CENTER	FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A		COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	THOI TWITE	DATE
	system six months	after the annual fire alarm		Maintenance Director	has	
	inspection was not			completed a visual ins	pection	
	1			of the fire alarm system	-	
	The finding was re	eviewed with the Maintenance		Education was comple		
	-	intenance Director, DON,		ensure Maintenance		
					la va ta va d	
		the Regional Director via		Director/Designee und		
	phone call during	the exit conference.		the facility procedure	related to	
				this inspection.		
	3.1-19(b)			4)How the corrective a	ictions	
				will be monitored:		
				The Maintenance		
				Director/designee will		
				complete a visual insp	ection of	
				the fire alarm systema		
				document this inspect		
				weekly to ensure prop		
				functioning of system		
				Maintenance Director/	-	
				will present the audit r	-	
				to the QAPI Committee	e during	
				QAPI Meetings to ensu	ure	
				completion of any new	/	
				necessary updates an		
				compliance. The audit		
				reviewed in Quality As		
				Meeting monthly for 6		
				or until 100% complian		
				achieved. The QA Cor		
				will identify any trends	s or	
				patterns and make		
				recommendations to r	evise the	
				plan of correction as i	ndicated.	
				5) Date of compliance		
				11/30/2022		
0353						
	NFPA 101					
SS=E		- Maintenance and Testing				
Bldg. 01		- Maintenance and Testing				
		ler and standpipe systems				
	are inspected, te	sted, and maintained in				
	1					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155249	A. BUILDING B. WING	<u>01</u>	COMPLETED 11/10/2022
	1	R DN AND HEALTHCARE CENTER STATEMENT OF DEFICIENCIE	6006 B	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815	(X5)
PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLET
	accordance with Inspection, Testin Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkl 9.7.5, 9.7.7, 9.7.8 Based on observat failed to ensure 6 of laundry were not be material in accorda 2011 edition, at 5.7 signs of leakage; si foreign materials, j shall be installed in up-right, pendent, 5.2.1.1.2 any sprin the following shall Corrosion (3) Phys the glass bulb heat Loading (6) Paintin sprinkler manufact could affect staff a smoke compartme Findings include: Based on observatt Assistant, U.P. Ma Administrator on I	NFPA 25, Standard for the ag, and Maintaining of Protection Systems. m design, maintenance, sting are maintained in a and readily available. r system last checked d system test supply source RKS information on non-required or partial er system. 8, and NFPA 25 on and interview, the facility of 6 sprinkler heads in the baded and covered with foreign ance with LSC 9.7.5. NFPA 25, 2.1.1.1 sprinklers shall not show hall be free of corrosion, baint, and physical damage; and an the correct orientation (e.g., for sidewall). Furthermore, at kler that shows signs of any of be replaced: (1) Leakage (2) ical Damage (4) Loss of fluid in responsive element (5) ng unless painted by the urer. This deficient practice and up to 25 residents in one	K 0353	K353 Sprinkler System Maintenance and Testing The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does n constitute admission or agreement by the provider of the truth of the facts alleged of conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becau- it is required by the provision of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding.	f of ot or le f se is

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DA'	TE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155249	A. BUILDING B. WING	01		ipleted 10/2022
	PROVIDER OR SUPPLIE		6006 B	ADDRESS, CITY, STATE, ZIP BRANDY CHASE COVE WAYNE. IN 46815	COD	
CHATEA (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE) REGULATORY O dirt and lint. Base observation, the M confirmed the sprin loaded with dirt an The finding was re Assistant, U.P. Ma Administrator, and	STATEMENT OF DEFICIENCIE STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> d on interview at the time of aintenance Assistant nkler heads in the laundry were d lint. weiewed with the Maintenance intenance Director, DON, the Regional Director via the exit conference.	R FORT	 WAYNE, IN 46815 PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTIONS) CROSS-REFERENCED TO THE DEFICIENCY) 2)How the facility ide other residents: All residents that res community have the to be affected by the deficient practice 3) Measures put into System changes: Sprinkler heads note 2567 in laundry room been cleaned and ins in-house. 4)How the corrective will be monitored: The Maintenance Director/designee wi inspect 5 sprinkler he week to ensure prop cleanliness. Mainten Director/Designee wi audit to the QAPI Co during QAPI Meeting ensure completion o necessary updates a compliance. The repor reviewed in Quality A Meeting monthly for or until 100% complia achieved. The QA Co will identify any trend patterns and make recommendations to plan of correction as 	should be appropriate inde at the potential alleged place/ ed in the n have spected actions Il visually eads per er enance ill present mmittee is to f any new nd ort will be Assurance 6 months ance is ommittee ds or revise the indicated.	(X5) COMPLETION DATE

2U4G21

Facility ID: 000153

If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/10/2022	
		155249	B. WING			
	PROVIDER OR SUPPLIE	R N AND HEALTHCARE CENTER	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815	•	
-	-				(375)	
(X4) ID PREFIX TAG	(EACH DEFICIE)	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E COMPLETION	
		R ESCIDENTIFTING INFORMATION	170		DAIL	
< 0355 SS=E Bldg. 01	installed, inspect accordance with Portable Fire Ext 18.3.5.12, 19.3.5 Based on observat failed to ensure 1 of the chapel were ins NFPA 10, Standar 2010 Edition. Sect extinguishers other shall be installed u means. (1) Securel extinguishers. (2) I extinguishers. (2) I extinguisher manu approved for such recess. This deficitor residents in one sm Findings include: Based on observat with the Maintenan Maintenance Direct on 11/10/22 at 12:: extinguisher in the unsecured. Based observation, the M the extinguisher w unsecured. The finding was ret	inguishers anguishers are selected, ed, and maintained in NFPA 10, Standard for inguishers. .12, NFPA 10 ion and interview, the facility of 1 portable fire extinguishers in stalled in accordance with d for Portable Fire Extinguishers, ion 6.1.3.4 states portable fire r than wheeled extinguishers sing any of the following y on a hanger intended for the facture. (3) In a listed bracket purpose. (3) In a cabinet or wall ent practice could affect 20 noke compartment.	K 0355	K355 Portable Fire Extinguishers The facility requests paper compliance for this citation <i>This Plan of Correction is to</i> <i>center's credible allegation</i> <i>compliance.</i> <i>Preparation and/or executi</i> <i>this plan of correction doe</i> <i>constitute admission or</i> <i>agreement by the provider</i> <i>the truth of the facts allege</i> <i>conclusions set forth in the</i> <i>statement of deficiencies.</i> <i>plan of correction is prepar</i> <i>and/or executed solely bed</i> <i>it is required by the provise</i> <i>of federal and state law.</i> 1)Immediate actions taken those residents identified No resident was found to b <i>affected by the finding.</i> 2)How the facility identified other residents:	n. the of on of s not of of od or e The red tause tions for e	
	Assistant, U.P. Ma Administrator, and	intenance Director, DON, I the Regional Director via the exit conference.		All residents that reside at community have the potent to be affected by the allege deficient practice	tial	

	R MEDICARE & MEDI					-	1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	A. 1	MULTIPLE C BUILDING VING	ONSTRUCTION 01	(X3) DATE COMPI 11/10	
	PROVIDER OR SUPPLIE	R N AND HEALTHCARE CENTER		6006 B	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	3) Measures put into place/ System changes: The portable fire extinguish that was found in the chape the floor was mounted on th wall.	lon	DATE
					4)How the corrective action will be monitored: Maintenance Director/Desig will audit all existing fire extinguishers to ensure the are properly mounted. Thereafter, Maintenance Director/designee will audit fire extinguishers weekly to ensure they are properly mounted and secured. Au will be reviewed monthly wi the QAA Committee for 6 months or until 100% compliance is met.	y 5 dits	
< 0374 SS=E Bldg. 01	Barrie Subdivision of Bu Barrier Doors 2012 EXISTING Doors in smoke b solid bonded woo construction that Nonrated protect are permitted. Do fixed fire window are self-closing of	uilding Spaces - Smoke uilding Spaces - Smoke parriers are 1-3/4-inch thick po-core doors or of resists fire for 20 minutes. ive plates of unlimited height pors are permitted to have assemblies per 8.5. Doors r automatic-closing, do not and are not required to swing			5. Date of compliance: 11/30/2022		

TERS FO	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155249	B. WING	<u></u>	11/10/2022
		_	STREET	ADDRESS, CITY, STATE, ZIP COD	
AME OF	PROVIDER OR SUPPLIE	R		RANDY CHASE COVE	
CHATEA	AU REHABILITATIC	IN AND HEALTHCARE CENTER	FORT	WAYNE, IN 46815	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		egress travel. Door opening			
	provides a minim	um clear width of 32 inches			
	for swinging or ho	prizontal doors.			
	19.3.7.6, 19.3.7.8				
		on and interview, the facility	K 0374		11/30/202
		of 6 sets of smoke barrier doors		K374 Subdivision of Buildin	g
	would restrict the r	novement of smoke for at least		Spaces-Smoke Barrier Door	s
	20 minutes. LSC 1	9.3.7.8 requires doors in smoke			
	-	ly with LSC Section 8.5.4. LSC		The facility requests paper	
	·	ors in smoke barrier shall close		compliance for this citation.	
		g only the minimum clearance		This Plan of Correction is th	e
		er operation. This deficient		center's credible allegation	of
	practice could affe	ct 25 residents in C3-hall.		compliance.	
				Preparation and/or executio	n of
	Findings include:			this plan of correction does	not
				constitute admission or	
	Based on observati	on with the Maintenance		agreement by the provider of	of
	Assistant, U.P. Ma	intenance Director, DON, and		the truth of the facts alleged	lor
	Administrator on 1	1/10/22 at 1:55 p.m., the set of		conclusions set forth in the	
		s in C3-hall corridor would not		statement of deficiencies. 1	The
	close due to a patie	ent lift parked up against one of		plan of correction is prepare	
	the smoke doors.	This condition would leave the		and/or executed solely beca	nuse
		on activation of the fire alarm.		it is required by the provision	ons
	Based on interview	during the time of		of federal and state law.	
	observation, the U.	P. Maintenance Director stated			
	the door was part of	f a smoke barrier, was blocked		1)Immediate actions taken for	or
	form closing and re	emoved the lift.		those residents identified	
	The finding was re	viewed with the Maintenance		No resident was found to be	
	e	intenance Director, DON,		affected by the finding.	
		the Regional Director via			
	phone call during t	-		2)How the facility identified	
				other residents:	
	3.1-19(b)				
				All residents that reside at the	
				community have the potenti	
				to be affected by the alleged deficient practice	
				3) Measures put into place/	
				j wieasures put into piace/	

	R MEDICARE & MEDIC	1			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE C A. BUILDING B. WING	<u>01</u>	(3) DATE SURVEY COMPLETED 11/10/2022
	PROVIDER OR SUPPLIE	N AND HEALTHCARE CENTE	6006 B	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				System changes: Patient lift was removed and relocated to an appropriate location. C3-hall corridor smoke doors were evaluated and noted to safely open and close as required. No other doors were noted to have this concern. 4) How the corrective actions	
				a) now the corrective actions will be monitored: The Maintenance Director/designee will monitor a corridor smoke doors weekly to ensure doors are not blocked fro being able to open and close correctly. Maintenance Director/designee will bring aud to Quality Assurance Meeting monthly for 6 months. The QA Committee will identify any trend or patterns and make recommendations to revise the plan of correction as indicated 5) Date of compliance: 11/30/20	om its ds
< 0511 SS=E Bldg. 01	complies with NF Code, electrical w complies with NF Code. Existing ins service provided 18.5.1.1, 19.5.1.1 Based on observati	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life. , 9.1.1, 9.1.2 on and interview, the facility	K 0511	K511 Utilities Gas and Electric	11/30/202
		f 1 electrical panel on the d from energized parts. NFPA		The facility requests paper compliance for this citation.	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION <u>01</u>	× ,	E SURVEY PLETED
		155249	B. WING		- 11/1	0/2022
NAME OF	PROVIDER OR SUPPLIE	ER		TADDRESS, CITY, STATE, ZIP CO BRANDY CHASE COVE	DD	
CHATEA	U REHABILITATIO	ON AND HEALTHCARE CENTER	R FORT	WAYNE, IN 46815		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
		ates 230.62 Energized parts of shall be enclosed as specified		This Plan of Correction		
		arded as specified in 230.62(B).		center's credible alleg	alion or	
		rgized parts shall be enclosed		compliance. Preparation and/or exe	ocution of	
		ot be exposed to accidental		this plan of correction		
		guarded as in 230.62(B).		constitute admission of		
		gized parts that are not enclosed		agreement by the prov		
		on a switchboard, panelboard, or		the truth of the facts a		
		guarded in accordance with		conclusions set forth	-	
		. Where energized parts are		statement of deficienc	ies. The	
	guarded as provide	ed in 110.27(A)(1) and (A)(2), a		plan of correction is p	repared	
	means for locking	or sealing doors providing		and/or executed solely		
	access to energize	d parts shall be provided. This		it is required by the pr	ovisions	
	deficient practice	could 20 resident on C2-hall.		of federal and state law	w.	
	Findings include:			1)Immediate actions ta		
				those residents identif		
		ion with the Maintenance		No resident was found		
		intenance Director, DON, and		affected by the finding		
		11/10/22 at 1:40 p.m., in the				
		closet an electrical panel was not energized parts. The cover and		2)How the facility ident	tified	
		vas laying on the floor. Based		other residents: All residents that resid	la at tha	
	-	time of observation, the U.P.		community have the p		
		ctor agreed the electrical panel		to be affected by the a		
		and the Maintenance Assistant		deficient practice	negeu	
		back onto the panel.				
				3) Measures put into p	lace/	
	The finding was re	eviewed with the Maintenance		System changes:		1
		intenance Director, DON,		Correction was made	via	
		l the Regional Director via		proper placement of el	lectrical	1
	phone call during	the exit conference.		panel cover.		
	3.1-19(b)			4)How the corrective a will be monitored:	octions	
				The Maintenance		1
				Director/designee will	audit the	
				electrical panel cover	weekly	
				to ensure proper place	ement	1
				and present compliance	ce audits	

STATEMEN	NT OF DEFICIENCIES	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	N AND HEALTHCARE CENTER	6006	T ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE F WAYNE, IN 46815		
(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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
				monthly to the QAPI Commit during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will b reviewed in Quality Assurance Meeting monthly for 6 month or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise to plan of correction as indicates 5) Date of compliance: 11/30/2022	w ce s e he	
K 0712 SS=F Bldg. 01	alarm signal and a conditions. Fire d and unexpected t conditions, at leas The staff is familia aware that drills a routine. Where d 9:00 PM and 6:00 announcement m audible alarms. 19.7.1.4 through Based on record re failed to conduct fi quarters. LSC 19.7 conducted quarter! facility personnel (engineers, and adm signals and emerged	ay be used instead of 19.7.1.7 view and interview, the facility re drills on each shift for 4 of 4 2.1.6 states drills shall be y on each shift to familiarize nurses, interns, maintenance inistrative staff) with the ncy action required under This deficient practice affects	K 0712	K712: Fire Drills The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does no constitute admission or agreer	of t	11/30/202

STATEMENT OF DEF AND PLAN OF CORRI		x1) provider/supplier/clia identification number 155249	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/10/2022	
NAME OF PROVIDER		R R DN AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX (EA	SUMMARY ACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMP	
Findin Based Mainte Directo 9:35 a. docum a) The and thi b) The shift fi c) The second d) The shift fi Furthe drill w docum a third Based the Ma aforem not kno conduc The fir Assistz Admin	gs include: on records re- nance Assis or, DON, and m., the follo entation of <i>a</i> first quarter rd shift fire second quar- re drill. third quarter and third sh fourth quarter and third sh fourth quarter ithin the pass entation was shift fire dri on interview intenance A entioned dri bw when the ted. dding was re- ent, U.P. Ma istrator, and call during t (b)	eview with the with the tant, U.P. Maintenance d Administrator on 11/10/22 at wing shifts were missing a completed fire drill: of 2022 was missing the first drills. ter of 2022 was missing a third r of 2022 was missing a third has not been a third shift fire t 12 months and no s available to show the last time Il was conducted. v at the time of record review, ssistant stated the Ils were not conducted and did e last third shift fire drill was viewed with the Maintenance intenance Director, DON, the Regional Director via he exit conference.	TAG	by the provider of the truth of th facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents tha reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. All fire drills have been brought up to date and into compliance 4)How the corrective actions w be monitored: The Maintenance Director/designee will continue conduct Fire Drills per Life Safe Code. Maintenance Director/designee will bring fire drills to Quality Assurance Meeting for 6 months. The QA Committee will identify any tren or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	er t he ill to ety	ATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	A. BU	(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	R DN AND HEALTHCARE CENTER	R	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	(X5) COMPLETION
TAG K 0761	REGULATORY O	R LSC IDENTIFYING INFORMATION		IAG			DATE
SS=F Bldg. 01	interview, the facil smoke barrier door inspected and repa maintenance progr	eview, observation and ity failed to ensure 10 of 10 assemblies are routinely ired as part of the facility am. Also, the facility failed to ection and testing of 3 of 3 fire	К 0	761	K761-Maintencance, Inspec & Testing-Door The facility requests paper		11/30/202
	door assemblies ar assemblies met the NFPA 80 5.2.1 sta inspected and teste written record of th and kept for inspec 5.2.4.1 states fire of inspected from bot condition of door a states as a minimu verified: (1) No open holes either the door or f (2) Glazing, vision	d 2 of 2 oxygen room fire door requirements of NFPA 80. tes fire door assemblies shall be d not less than annually, and a ne inspection shall be signed tion by the AHJ. NFPA 80, loor assemblies shall be visually h sides to assess the overall assembly. NFPA 80, 5.2.4.2 m, the following items shall be or breaks exist in surfaces of			The facility requests paper compliance for this citation This Plan of Correction is t center's credible allegation compliance. Preparation and/or executi this plan of correction doe constitute admission or agreement by the provider the truth of the facts allege conclusions set forth in the statement of deficiencies. plan of correction is prepar and/or executed solely bec it is required by the provisit of federal and state law.	n. he of on of s not of of of or e The red ause	
	noncombustible th and in working orc damage. (4) No parts are m	s do not exceed clearances			 1)Immediate actions taken those residents identified No resident was found to b affected by the finding. 2)How the facility identified 	e	
	 (6) The self-closin the active door cor from the full open (7) If a coordinator closes before the a (8) Latching hardw door when it is in the 	g device is operational; that is, npletely closes when operated position. • is installed, the inactive leaf			All residents that reside at community have the potent to be affected by the allege deficient practice 3) Measures put into place/	the tial d	

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION NG <u>01</u>	(X3) DATE SURVEY COMPLETED 11/10/2022
	ROVIDER OR SUPPLIE	R DN AND HEALTHCARE CENTE	60	REET ADDRESS, CITY, STATE, ZIP 106 BRANDY CHASE COVE DRT WAYNE, IN 46815	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLETIC
	frame. (10) No field modi- have been perform (11) Gasketing and inspected to verify This deficient prace Findings include: Based on record re Maintenance Assis Director, DON, an between 10:00 a.m smoke/fire doors v A.) Annual inspect annual inspection assemblies and the available for revier S.) Routine inspect available for revier six corridor smoke smoke door in upp three attic smoke of mechanical room. C.) Open holes or the door or frame: therapy had six sm where a door coord D) Modifications to performed that voi labels on the six co the three corridor for	are not installed on the door or fications to the door assembly ed that void the label. It edge seals, where required, are their presence and integrity. tice could affect all residents. view and observations with the tant, U.P. Maintenance d Administrator on 11/10/22 and 3:00 p.m., the following vere not inspected or repaired: tions: no documentation of an for the three fire door two O2 room fire doors were <i>w</i> . tions: no documentation was w of a routine inspection for the door assemblies, the attic er mechanical room, and the loor hatches in upper breaks exist in surfaces of either the fire door assembly to all holes in the door frame dinator was removed. o the door assembly have been d the label: the fire door rating prridor smoke door assemblies, fire door assemblies, and the loors had paint completely and the door ratings could not		 System changes: A- Annual inspections-complete current up to date B-Routine inspection Inspection on all doo been complete and u C- Holes and break i frame have been cor D-All door labels hav cleaned and door rate now legible 4) How the corrective will be monitored: The Maintenance Director/designee will inspections moving for Maintenance Director will bring current and inspections to Quality Meeting monthly for 6 The QA Committee w any trends or patterns recommendations to 1 plan of correction as in 5) Date of compliance 	ns- ors have up to date n door and rrected ve been ting are e actions d monitor all orward. r/designee future v Assurance o months. vill identify s and make revise the indicated

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/10/2022		
	PROVIDER OR SUPPLIE	R N AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP CO RANDY CHASE COVE WAYNE, IN 46815	DD	, .	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
< 0914 SS=F Bldg. 01	Based on interview and observation, the the U.P. Maintena fire/smoke door in within the last yea painted, and the the holes in the frame. The finding was rea Assistant, U.P. Ma Administrator, and phone call during to 3.1-19(b) NFPA 101 Electrical System Testing Electrical System Testing Hospital-grade rea locations and wh anesthesia is addi initial installation, Additional testing defined by docum Receptacles not these locations a exceeding 12 mod (LIM), if installed less than or equal the LIM test switch activates both vis LIM circuits with manual test is per than or equal to the read to the Records are main	v at the time of records review ne Maintenance Assistant and nce Director stated the spection were not completed r, all rated doors had the labels erapy fire door assembly had					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DAT	TE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLETED	
		155249	B. WI	B. WING		11/10/2022	
NAME OF	PROVIDER OR SUPPLIE	P		STREET	ADDRESS, CITY, STATE, ZIP COD		
					RANDY CHASE COVE		
CHATE		ON AND HEALTHCARE CENTER		FORT	WAYNE, IN 46815		
X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE OPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	oom or area tested, and					
	results.						
	6.3.4 (NFPA 99)						
		ion, record review, and	K 0	914	K914 Electrical Systems		11/30/2022
		ity failed to ensure electrical			Maintenance and Testing		
	-	f 82 resident sleeping rooms			The facility requests paper		
		annually for non-hospital			compliance for this citati	on.	
	-	tially for hospital grade			This Plan of Correction is	s the	
	receptacles. NFPA	99, Health Care Facilities Code			center's credible allegati	on of	
	2012 Edition, Sect	ion 6.3.4.1.3 states receptacles			compliance.		
	not listed as hospit	al-grade, at patient bed			Preparation and/or execu	ition of	
	locations and in lo	cations where deep sedation or			this plan of correction do	oes not	
	general anesthesia	is administered, shall be tested			constitute admission or		
	at intervals not exc	eeding 12 months.			agreement by the provid	er of	
	Additionally, Section	on 6.3.3.2, Receptacle Testing			the truth of the facts alle		
	in Patient Care Ro	oms requires the physical			conclusions set forth in	the	
	integrity of each re	ceptacle shall be confirmed by			statement of deficiencies	. The	
	visual inspection.	The continuity of the			plan of correction is prep	bared	
	grounding circuit i	n each electrical receptacle shall			and/or executed solely b		
	be verified. Corre	ct polarity of the hot and neutral			it is required by the prov		
		h electrical receptacle shall be			of federal and state law.		
		ention force of the grounding					
		rical receptacle (except			1)Immediate actions take	n for	
		tacles) shall be not less than			those residents identified		
		es). This deficient practice			No resident was found to		
	could affect all pat				affected by the finding.		
	Findings include:				2)How the facility identifi	od	
	i manigo monude.				other residents:	u a	
	Based on observat	ions with the Maintenance			All residents that reside a	at the	
		intenance Director, DON, and			community have the pote		
		1/10/22 between 11:00 a.m. and			to be affected by the alleg		
		ity's resident sleeping rooms			deficient practice		
	-	ight electrical receptacles with a					
		l non-hospital grade			3) Measures put into plac	:e/	
		l on records review at 10:10			System changes:		
	-	documentation available to			Facility has completed th		
		sting for the sleeping rooms.					
	-	v at the time of the observation			annual receptacle testing		
		<i>y</i> , the Maintenance Assistant			has corrected all faults for	Juliu.	
	and records review	, me mannenance Assistant			1		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		COM	(X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	R R DN AND HEALTHCARE CENTER	-	6006 E	ADDRESS, CITY, STATE, ZIP (RANDY CHASE COVE WAYNE, IN 46815	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	The finding was re Assistant, U.P. Ma Administrator, and	les will need to be tested. viewed with the Maintenance intenance Director, DON, the Regional Director via he exit conference.			 4)How the corrective will be monitored: The Maintenance Director/designee will an audit of 10 rooms the QAPI Committee QAPI Meetings to ensite completion of any nenecessary updates at compliance. The report reviewed in Quality A Meeting monthly for or until 100% complianation of any trence patterns and make recommendations to plan of correction as 5) Date of Compliance 	I present monthly to during sure w nd ort will be assurance 12 months ance is ommittee is or revise the indicated.	
< 0918 SS=F Bldg. 01	Electrical System System Maintena The generator of source and association of supplying serv 10-second criteria monthly test, a pri- annually confirm safety and critica and testing of the switches are perf NFPA 110. Generator sets a exercised under year in 20-40 day once every 36 m	as - Essential Electric Syste is - Essential Electric ince and Testing rother alternate power ciated equipment is capable ice within 10 seconds. If the on is not met during the rocess shall be provided to this capability for the life I branches. Maintenance e generator and transfer formed in accordance with re inspected weekly, oad 30 minutes 12 times a r intervals, and exercised poths for 4 continuous hours. nder load conditions include					

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	R ON AND HEALTHCARE CENTER	6006	ET ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE T WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETI DATE	
	automatic or man loads, and are co personnel. Maint energy power so accordance with circuit breakers a program for perio components is e manufacturer rec of maintenance a and readily avail and circuits are r and separate fro Minimizing the p emergency power consideration for 6.4.4, 6.5.4, 6.6. NFPA 111, 700. Based on observat interview; the faci diesel power gene 99 2012 Chapter (generator serving to be in accordance for Emergency an Chapter 8. This de occupants. Findings include: Based on records Assistant and the 11/10/22 at 9:05 a documentation wa A.) Generator exe minimum of 30 m	ion, records review, and lity failed to maintain 1 of 1 rators in accordance with NFPA o which requires testing of the the emergency electrical system e with NFPA 110, the Standard d Standby Powers Systems, ficient practice could affect all review with the Maintenance U.P. Maintenance Director on .m., the following required testing is not available for review: rcised under load monthly for a inutes. The required monthly load ducted for the months of	K 0918	K918: Electrical Systems The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does no constitute admission or agree by the provider of the truth of facts alleged or conclusions as forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken fo those residents identified No resident was found to be affected by the finding.	of ot ement the set	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDIC	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	OMI (X3) DATE S	B NO. 0938-039 Survey
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155249	A. BU B. W	JILDING NG	01	COMPLETED 11/10/2022	
NAME OF	PROVIDER OR SUPPLIEI	ξ			ADDRESS, CITY, STATE, ZIP COD	-	
CHATEA	U REHABILITATIO	N AND HEALTHCARE CENTER			RANDY CHASE COVE WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
IAU	REGULATORY OF	R LSC IDENTIFYING INFORMATION		IAU	2)How the facility identified ot	her	DATE
	B.) Generator inspected weekly. A total of 17 weeks were missing the weekly inspections.				residents:		
					Visitors, staff and residents th	at	
					reside at the community have		
		nk test for the diesel generator.			potential to be affected by the		
		ly load test indicated the load			alleged deficient practice		
		e facility is required to have an			3) Measures put into place/		
		st due to the load being under tation of an annual load bank			System changes:		
	was provided for re				a. 30 Minute Generator Load Exercise has been completed		
	was provided for re	view.			is currently up to date.	anu	
	D.) Four hour run u	under load. The facility is			b. Weekly Generator inspect	ions	
		our-hour run under load once			are being completed and are		
		No documentation of a			currently up to date.		
		provided for review.			c. Annual Load Bank Inspec	tion	
					has been completed and is		
	E.) Emergency gen	erator light testing. The battery			currently up to date.		
		task lighting testing for 30			d. 3-year 4 hour run under lo	ad	
	seconds monthly w	as not conducted.			has been completed and is		
					currently up to date.		
		ew at the time of record review,			e. Emergency Generator ligh		
		ssistant and the U.P.			testing has been completed a	nd is	
		tor stated the testing and nation for the generator was			currently up to date. 4)How the corrective actions		
	lost or not complete				4)How the corrective actions to be monitored:	/v111	
	-	tor and no other generator			The Maintenance		
	paperwork could be				Director/designee will continu	e to	
					conduct and schedule Genera		
	The finding was re-	viewed with the Maintenance			Inspections accordingly.		
		ntenance Director, DON,			Maintenance Director/designe	e	
		the Regional Director via			will bring inspections to Qualit		
	phone call during the	ne exit conference.			Assurance Meeting for 6 mon		
					The QA Committee will identif	-	
	3.1-19(b)				any trends or patterns and ma		
					recommendations to revise the plan of correction as indicated		
					5) Date of compliance:		
					11/30/2022		

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Event ID:

2U4G21 Facility ID: 000153

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STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	S X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 11/10/2022	
NAME OF PROVIDER OR SUF	PLIER TION AND HEALTHCARE CENTE	6006	r address, city, state, zip cod BRANDY CHASE COVE WAYNE, IN 46815		
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIE CIENCY MUST BE PRECEDED BY FULL AY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE	
Bldg. 01 Extens Electrical Equ Extension Co Power strips used for com patient-care-I (PCREE) ass assembled by the condition the patient ca non-PCREE except in long do not use P meet UL 136 for non-PCRI (outside of vi non-patient c other UL star used with get cords are not wiring of a stat temporarily a completion of installed and 10.2.3.6 (NFI (NFPA 70), 5 Based on obse failed to ensur and power stri safe manor, ar 1363A or 606 accordance wi was found threa affect all resid	n a patient care vicinity are only ponents of movable elated electrical equipment embles that have been qualified personnel and meet of 10.2.3.6. Power strips in re vicinity may not be used for e.g., personal electronics), term care resident rooms that CREE. Power strips for PCREE BA or UL 60601-1. Power strips E in the patient care rooms tinity) meet UL 1363. In are rooms, power strips are teral precautions. Extension used as a substitute for fixed ucture. Extension cords used re removed immediately upon the purpose for which it was meets the conditions of 10.2.4. PA 99), 10.2.4 (NFPA 99), 400-8 90.3(D) (NFPA 70), TIA 12-5 tration and interview, the facility e 11 of 11 flexible extension cords os were installed properly, used in a d met the required UL rating of 1-1 in patient care locations in h NFPA 99. This deficient practice ughout the building therefore can ents.	K 0920	K920 Electrical Equipment- Power Cords and Extension Cords The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution this plan of correction does a constitute admission or	f n of	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155249	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/10/2022
	PROVIDER OR SUPPLIE	R NN AND HEALTHCARE CENTER	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815	
CHATE/ (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY O Assistant, U.P. Ma Administrator on 1 3:15 p.m., the follo or improper use of A.) A coffee pot (h was plugged into a strip in the Unit Ma B.) In the Unit Ma to power equipmer dangling from a fil C.) In the B-wing p power equipment, dangling from the o D.) Extension cord 134 and 211. E.) Power-strips in and 211 were in us area that did not m Based on interview Maintenance Assis Director, DON, an acknowledged pow	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> intenance Director, DON, and 1/10/22 between 11:00 a.m. and owing rooms had extension cords power-strips: high power draw equipment) nd supplied power by a power anager office. nager office a power strip used at, was not secured, and was ing cabinet.			DATE DATE
Ass Adr pho	Assistant, U.P. Ma	viewed with the Maintenance intenance Director, DON, the Regional Director via he exit conference.		 3.B-wing pantry power stri was secured appropriately. 4.Extension cords in Resid Rooms 134 and 211 were removed. 5.Power strips noted in resident rooms 134, 127, 123 121, 216 and 211 were removed. 4)How the corrective actions will be monitored: 	lent 3,

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	R MEDICARE & MEDI					1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	N AND HEALTHCARE CENTER	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	The Maintenance Director/designee will complete a documented w inspection of 5 random of or resident rooms weekly ensure no unapproved po strips are present and tha approved power strips are properly secured. Maintenance Director/des will present the audit mon to the QAPI Committee du QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will reviewed in Quality Assur Meeting monthly for 6 mo or until 100% compliance achieved. The QA Commit will identify any trends or patterns and make recommendations to revis plan of correction as indic 5) Date of compliance: 11/30/2022	fices to wer t e ignee thly tring I be ance nths is ittee	DATE
K 0923 SS=E Bldg. 01	Storag Gas Equipment - Storage Greater than or e Storage locations and ventilated in and 5.1.3.3.3. >300 but <3,000 Storage locations enclosure or with	Cylinder and Container Cylinder and Container equal to 3,000 cubic feet s are designed, constructed, accordance with 5.1.3.3.2 cubic feet s are outdoors in an in an enclosed interior limited- combustible				

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED	
		155249	B. WING		11/10/2022	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD		
		ON AND HEALTHCARE CENTER		3RANDY CHASE COVE WAYNE, IN 46815		
				WATNE, IN 40013		
(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 APPROPRIATE		
TAG		DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		n door (or gates outdoors)				
		red. Oxidizing gases are not				
		nables, and are separated				
		es by 20 feet (5 feet if				
		nclosed in a cabinet of				
		construction having a				
		fire protection rating.				
		al to 300 cubic feet				
	-	e compartment, individual				
		le for immediate use in				
		s with an aggregate volume				
		qual to 300 cubic feet are not				
		ored in an enclosure.				
	as specified in 1	e handled with precautions				
		sign readable from 5 feet is				
		gate of a cylinder storage				
		sign includes the wording as				
		JTION: OXIDIZING GAS(ES)				
		N NO SMOKING."				
		ed so cylinders are used in				
		ey are received from the				
		cylinders are segregated				
		s. When facility employs				
		egral pressure gauge, a				
	threshold pressu	re considered empty is				
		pty cylinders are marked to				
	avoid confusion.	Cylinders stored in the open				
	are protected fro	m weather.				
	11.3.1, 11.3.2, 1	1.3.3, 11.3.4, 11.6.5 (NFPA				
	99)					
		ion and interview, the facility	K 0923	K923 Gas Equipment Cylinder	r 11/30/20	
		of 4 cylinders of nonflammable		and Container Storage		
		gen were properly secured from		The facility requests paper		
		Health Care Facilities Code,		compliance for this citation.		
		tion 11.3.2 states storage for		This Plan of Correction is the		
	-	es greater than 8.5 cubic meters		center's credible allegation of	7	
		it less than 85 cubic meters		compliance.		
		shall comply with 11.3.2.1		Preparation and/or execution		
	I through 11.3.2.3.	NFPA 99, Section 11.3.2.6 states	1	this plan of correction does n	ot I	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155249		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	R N AND HEALTHCARE CENTER	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OD cylinder or contain 11.6.2.3. Section 1 cylinders shall be p in a proper cylinde practice could affect Findings include: Based on observati Assistant, U.P. Ma Administrator on 1 C-wing oxygen sto type oxygen cylind the floor and were supported in a prop Based on interview Administrator ackr cylinders in the C-v storage/trans-filling chained or support cart. The finding was re Assistant, U.P. Ma	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION er restraints shall comply with 1.6.2.3(11) states freestanding properly chained or supported r stand or cart. This deficient et 40 on the C-wing. ons with the Maintenance intenance Director, DON, and 1/10/22 at 2:04 p.m., in the rage/trans-filling room four 'E' lers were standing upright on not properly chained or ber cylinder stand or cart. r at the time of observation, the nowledged four 'E' type oxygen wing oxygen g room were not properly ed in a proper cylinder stand or viewed with the Maintenance intenance Director, DON, the Regional Director via	ID PREFIX TAG	 WAYNE, IN 46815 PROVIDERS PLAN OF CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPRODUCTS ACTION SHOLL CROSS-REFERENCED TO THE APPRODUCTION CONSTRUCT ACTION SHOLL CROSS-REFERENCED TO THE APPRODUCTS. Constitute admission or agreement by the provide the truth of the facts alleg conclusions set forth in t statement of deficiencies plan of correction is prep and/or executed solely be it is required by the provide of federal and state law. 1)Immediate actions taken those residents identified No resident was found to affected by the finding. 2)How the facility identified other residents: All residents that reside a community have the pote to be affected by the alleg deficient practice 3) Measures put into plac System changes: All cylinders noted in the have been properly securioxygen rooms. 4)How the corrective action will be monitored: The Maintenance Director/designee will re-educate staff on prope storage and securing of contents to ensure safe s and present the audit monitored in the audi	Participartie Completing Date Date Date Date Date Date Date Date

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	R MEDICARE & MEDIC			ONCEDUCTION	-	MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155249	A. BUILDING B. WING	<u></u>		(X3) DATE SURVEY COMPLETED 11/10/2022	
	PROVIDER OR SUPPLIE	R N AND HEALTHCARE CENTER	6006 E	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE	
				to the QAPI Committee du QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will reviewed in Quality Assura Meeting monthly for 6 mor or until 100% compliance if achieved. The QA Commit will identify any trends or patterns and make recommendations to revis plan of correction as indic Date of compliance: 11/30/2	ll be ance aths s ttee e the ated.		
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxy another is in acco Transfilling of Hig Oxygen Used for any gas from one prohibited in patie to liquid oxygen of containers over 5 under 11.5.2.3.1 liquid oxygen cor containers under 11.5.2.2 (NFPA 9 Based on observati failed to ensure tra in 1 of 2 oxygen tr separated from any accordance with N and failed to provis	Transfilling Cylinders Transfilling Cylinders ogen from one cylinder to ordance with CGA P-2.5, h Pressure Gaseous Respiration. Transfilling of cylinder to another is ent care rooms. Transfilling ontainers or to portable 0 psi comply with conditions (NFPA 99). Transfilling to tainers or to portable 50 psi comply with 11.5.2.3.2 (NFPA 99). 9) on and interview, the facility nsfilling of oxygen took place ansfilling rooms that are portion of a facility in FPA 99 2012 edition 11.5.2.3.1., de proper signage in FPA 99 11.5.2.3.1(3). This ould affect up to 40 residents in	К 0927	K927 Gas Equipment- Transfilling Cylinders The facility requests paper compliance for this citatio This Plan of Correction is center's credible allegation	n. <i>th</i> e	11/30/202	

	R MEDICARE & MEDIC					-	MB NO. 0938-03
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155249		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 11/10/2022		
	PROVIDER OR SUPPLIE		2	6006 B FORT	ADDRESS, CITY, STATE, ZIP COD BRANDY CHASE COVE WAYNE, IN 46815		-
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD)	N BE	(X5) COMPLETIO
TAG				TAG	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DPRIATE DAT	
	B-wing.				compliance.		
	 Assistant, U.P. Ma Administrator on 1 following was obse storage/transfer room A.) The oxygen transfer room A.) The oxygen transfer room A.) The oxygen transfer room concentrators and one optimized completely filling in condition dose not person transfilling the door closed. B.) The door to the was not provided with the indicates when occurring. Based on interview Administrator and O2 room were not door, and the extrator and the extrator and the finding was ree Assistant, U.P. Ma Administrator, and 	AR SUPPLIER BILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION include: n observation with the Maintenance t, U.P. Maintenance Director, DON, and trator on 11/10/22 at 1:15 p.m., the g was observed at the B-wing oxygen ransfer room: oxygen transfilling room contained liquid anks, oxygen cylinders, oxygen ators and other oxygen supplies ely filling the room to the door. This n dose not leave enough room for a ansfilling oxygen inside the room with closed. door to the room oxygen transfilling room provided with caution signs nor a sing cates when transfilling of oxygen is g. n interview at the time of observation, the trator and DON stated the signs for the were not reinstalled after painting of the d the extra items will need to be removed room for a person transfilling oxygen. ing was reviewed with the Maintenance t, U.P. Maintenance Director, DON, trator, and the Regional Director via ll during the exit conference.			Preparation and/or execute this plan of correction doe constitute admission or agreement by the provided the truth of the facts alleg conclusions set forth in the statement of deficiencies. plan of correction is prepa- and/or executed solely be it is required by the provis- of federal and state law. 1)Immediate actions taken those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: All residents that reside afficient practice 3) Measures put into place System changes: Maintenance Director/Des has corrected the two oxy transfilling rooms as follow 1.Oxygen Transfilling roo (A) was cleaned out to allow enough room for a person transfilling oxygen to clos door. 2.Oxygen Transfilling roo (B) was properly labeled we the correct signage. 4)How the corrective action will be monitored: The Maintenance Director/designee will	es not r of ed or be The ared cause sions a for be d t the ntial ed y ignee gen ws: om ow e the om	

ENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155249		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/10/2022	
	ROVIDER OR SUPPLIE	R R N AND HEALTHCARE CENTER	6006 B	ADDRESS, CITY, STATE, ZIP COD RANDY CHASE COVE WAYNE, IN 46815	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
				complete a documented vis inspection of both oxygen transfilling rooms weekly to ensure proper signage is posted and that the rooms a free of supplies to allow closing during filling. Maintenance Director/desig will present the audit month to the QAPI Committee durin QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will b reviewed in Quality Assurar Meeting monthly for 6 mont or until 100% compliance is	are nee Ily ng De nce hs	
				achieved. The QA Committee will identify any trends or patterns and make recommendations to revise plan of correction as indicat 5) Date of compliance: 11/30/2022	ee the	

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