	Г OF HEALTH AND HU						RM APPROVED
	R MEDICARE & MEDIC					-	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER					COMPL	
		155654	B. WI	NG		10/24	2022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER		FORT	WAYNE, IN 46809		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
	An Emergency Pre	paredness Survey was	E 00	000	The creation and submissior	n of	
	conducted by the In	ndiana Department of Health in			the Plan of Correction does	not	
	accordance with 42	2 CFR 483.73.			constitute an admission by the	nis	
					provider of any conclusion se		
	Survey Date: 10/2	4/22			in the statement of deficience		
					of any violation or regulation	. This	
	Facility Number: (000498			provider respectfully request		
	Provider Number:	155654			the 2567 PLAN OF CORREC		
	AIM Number: 100	0266110			BE CONSIDERED THE LET		
					OF CREDIBLE ALLEGATIO		
	At this Emergency	Preparedness survey,			AND REQUESTS A DESK		
		& Rehabilitation Center was			REVIEW FOR PAPER		
	found in compliance				COMPLIANCE IN LIEU OF	4	
		irements for Medicare and			POST SURVEY REVISIT on		
		ting Providers and Suppliers, 42			after November 9, 2022.		
	CFR 483.73.						
	-	certified beds. At the time of					
	the survey, the cen	sus was 53.					
	Quality Review co	mpleted on 10/24/22					
K 0000							
Bldg. 01							
5.	A Life Safety Code	e Recertification and State	K 0	000	The creation and submissior	n of	
		was conducted by the Indiana		000	the Plan of Correction does		
		lth in accordance with 42 CFR			constitute an admission by th		
	483.90(a).				provider of any conclusion se		
					in the statement of deficience		
	Survey Date: 10/2	4/2.2			of any violation or regulation		
					provider respectfully request		
	Facility Number: (000498			the 2567 PLAN OF CORREC		
	Provider Number:				BE CONSIDERED THE LET		
	AIM Number: 100				OF CREDIBLE ALLEGATIO		
		200110			AND REQUESTS A DESK		
		Code survey, Englewood			REVIEW FOR PAPER		
	At this 1 ito Votativ						

	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
_	Christian Livingston	Administrator		11/04/2022
	Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may	be excused from correcting p	roviding it is determin	
	other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing	g homes, the findings stated a	bove 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.

000498

	R MEDICARE & MEDIC					B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				SURVEY ETED
155654		B. WING	<u></u>	10/24/2022		
NAME OF	PROVIDER OR SUPPLIEI	R		f address, city, state, zip cod ENGLE RD	-	
ENGLEV	VOOD HEALTH & F	REHABILITATION CENTER		WAYNE, IN 46809		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
		ation Center was found not in equirements for Participation		COMPLIANCE IN LIEU OF A POST SURVEY REVISIT on (
	-	l, 42 CFR Subpart 483.90(a),		after November 9, 2022.	JI .	
		ire and the 2012 Edition of the				
	-	ction Association (NFPA) 101,				
		LSC), Chapter 19, Existing				
		ancies and 410 IAC 16.2.				
	This one story facil	ity was determined to be of				
		truction and fully sprinklered.				
		ire alarm system with smoke				
		ridors, in all areas open to the				
		rd wired smoke detectors in all				
		poms. The facility has a				
	of this visit.	had a census of 53 at the time				
	All areas where res	idents have customary access				
		All areas providing facility				
	-	klered except for two detached				
	storage buildings.	-				
	Quality Review con	mpleted on 10/24/22				
0211	NFPA 101					
SS=E	Means of Egress					
3ldg. 01	Means of Egress					
		ays, corridors, exit				
	-	ocations, and accesses are h Chapter 7, and the means				
		n Chapter 7, and the means				
	-	full use in case of				
		s modified by 18/19.2.2				
	through 18/19.2.1	-				
	18.2.1, 19.2.1, 7.4	1.10.1				
		on and interview, the facility	K 0211	K211 Means of Egress - Gen	eral	11/09/202
		f 6 means of egress were		Plan of Correction		
		ained free of all obstructions			(-)	
		full instant use in the case of ency. This deficient practice		1. What corrective action		
	inre or other emerge	ency. This deficient practice		will be accomplished for tho	se	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 155654 B. WING 10/24/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2237 ENGLE RD **ENGLEWOOD HEALTH & REHABILITATION CENTER** FORT WAYNE, IN 46809 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE could affect 15 residents in the Memory Care hall. residents found to have been affected by the deficient Findings include: practice? At the time the deficiency was Based on an observation with the Maintenance identified. no residents were found Director on 10/24/22 at 11:30 a.m., by the Memory to have been affected by the Care exit door there were over 20 boxes of deficient practice. supplies being stored in the corridor. Based on an interview at the time of observation, the How other residents 2 Maintenance Director stated supplies were stored having the potential to be in the corridor due to lack of storage space in the affected by the same deficient building. practice will be identified and what corrective action(s) will The finding was reviewed with the Administrator be taken? and Maintenance Director during the exit All residents on our Memory hall, conference. 15 residents total, had the potential to be affected. 3.1-19(b) 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? The boxes were removed immediately and placed in appropriate storage locations. An additional storage bin has been purchased for inventory. Facility is currently waiting for storage bin to arrive to store excess inventory. How will the corrective 4. action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed. The supplies will no longer be FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4P7I21 Facility ID: 000498 Page 3 of 11 If continuation sheet

11/14/2022

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ENTERS FO	R MEDICARE & MEDIC					MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	COM	e survey pleted 4/2022	
	T	REHABILITATION CENTER	2237	ET ADDRESS, CITY, STATE, ZIP COD ENGLE RD T WAYNE, IN 46809		(X5)
PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N E RIATE	COMPLETION
K 0355 SS=E Bldg. 01	WOOD HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff in the kitchen.		K 0355	 stored near the memory car door. We will immediately p all inventory in designated inventory closet locations. K355 Portable Fire Extinguishers Plan of Correction 1. What corrective action will be accomplished for the residents found to have be affected by the deficient practice? At the time the deficiency we identified, no residents were to have been affected by the deficient practice. 2. How other residents having the potential to be affected by the same defic practice will be identified a what corrective action(s) were to no residents 	e exit face n(s) nose een vas found e ient nd	11/09/202
Base Direc K-cla	Director on 10/24/ K-class fire exting	on with the Maintenance 22 at 12:49 p.m., the portable aisher located in the kitchen did bicuously placed placard near		be taken? No residents had the poten be affected regarding the de practice; however, all 5 staf members in the kitchen had potential to be affected, but employee was.	eficient the	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY	
AND PLAN OF CORRECTION		RECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED	
		155654	B. WING		10/2	4/2022	
NAME OF	PROVIDER OR SUPPLIE	P	STREET	ADDRESS, CITY, STATE, ZIP C	COD		
				NGLE RD			
ENGLEV	NOOD HEALTH & I	REHABILITATION CENTER	FORT	WAYNE, IN 46809			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	-	hich states the fire protection					
		ivated prior to using the fire		3. What measures			
	-	ed on interview at the time of aintenance Director agreed		put into place or wha	-		
		card installed for the K-class		changes will be made ensure that deficient			
	fire extinguisher.	care instance for the K-class		does not recur?	practice		
	ine energenerer			A K-class fire extinguis	sher placard		
	The finding was re	viewed with the Administrator		was ordered to be place	-		
	and Maintenance I	Director during the exit		extinguisher.			
	conference.						
				4. How will the cor			
	3.1-19(b)			action(s) be monitore			
				ensure the deficient p	oractice		
				will not recur?			
				ie: what QA program put into place and by			
				date will they be com			
				The placard will be pla	iced next to		
				the extinguisher and w			
				moved. The placard ha			
				expected delivery date	e of		
				11/7/2022.			
(0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
-	Doors protecting	corridor openings in other					
		closures of vertical openings,					
		us areas resist the passage					
		made of 1 3/4 inch					
		e wood or other material					
		ng fire for at least 20					
		n fully sprinklered smoke					
		e only required to resist the e. Corridor doors and doors					
	to rooms containi						
		erials have positive latching					
		latches are prohibited by					
		These requirements do not					
		-		1		1	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155654	A. BUII B. WIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 10/24/2022	
	PROVIDER OR SUPPLIE	R REHABILITATION CENTER		2237 E	address, city, state, zip cod NGLE RD WAYNE, IN 46809		
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETIC DATE
	flammable or corr Clearance betwee covering is not ex doors complying if provided with a the door closed w applied. There is closing of the door release when the permitted. Nonra unlimited height a meeting 19.3.6.3 frames shall be la other materials in unless the smoke sprinklered. Fixe allowed per 8.3. there are no rest resistance of glas assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMAR fire protection rat devices, etc. Based on observat failed to ensure 1 of doors resist the par resisting fire for at practice could affe Findings include: Based on observat Director on 10/24/ corridor door to ro that went through	spaces that do not contain nbustible material. en bottom of door and floor (ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is a no impediment to the ors. Hold open devices that e door is pushed or pulled are ted protective plates of are permitted. Dutch doors .6 are permitted. Door abeled and made of steel or a compliance with 8.3, e compartment is d fire window assemblies are in sprinklered compartments rictions in area or fire as or frames in window 2. Parts 403, 418, 460, 482, KS details of doors such as ings, automatics closing ion and interview, the facility of 35 resident room corridor ssage of smoke and capable of least 20 minutes. This deficient ct 2 residents in room 306.	K 030	53	K363 Corridor - Doors Plan of Correction 1. What corrective actio will be accomplished for the residents found to have be affected by the deficient practice? At the time the deficiency we identified, no residents were to have been affected by the deficient practice.	ose en as found	11/09/20

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155654	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 10/24/2022	
	PROVIDER OR SUPPLIE	REHABILITATION CENTER		2237 E	ADDRESS, CITY, STATE, ZIP COD NGLE RD WAYNE, IN 46809		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DN BE PRIATE	(X5) COMPLETIO DATE
	handle. The finding was re	s due the switching the door wiewed with the Administrator ce Director during the exit			2. How other residents having the potential to be affected by the same defic practice will be identified what corrective action(s) be taken? Two residents had the pote be affected by the deficient practice.	and will ential to	
					 What measures will put into place or what sys changes will be made to ensure that deficient practices not recur? The door handle was immereplaced, and an expansion was installed to seal the horizontal search of the correction. How will the correction 	temic tice ediately plate les.	
					action(s) be monitored to ensure the deficient pract will not recur? ie: what QA program will I put into place and by wha date will they be complete	be t ed.	
					All door handles properly so resist the passage of smok are capable of resisting fire least 20 minutes. No door h will be switched out without maintenance approval to en the deficient practice will no recur.	e and for at nandles t nsure	
(0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Utilities - Gas and						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 10/24/2022 155654 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2237 ENGLE RD FORT WAYNE, IN 46809 **ENGLEWOOD HEALTH & REHABILITATION CENTER** (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 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility K 0511 K511 Utilities – Gas and Electric 11/09/2022 failed to ensure 1 of 1 receptacles within 6 feet Plan of Correction from a sink were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with 1. What corrective action(s) Section 9.1. LSC 9.1.2 requires electrical wiring will be accomplished for those and equipment to comply with NFPA 70, National residents found to have been Electrical Code. NFPA 70, NEC 2011 Edition at affected by the deficient 210.8 Ground-Fault Circuit-Interrupter Protection practice? for Personnel, states, ground-fault At the time the deficiency was circuit-interruption for personnel shall be identified, no residents were found provided as required in 210.8(A) through (C). The to have been affected by the ground-fault circuit-interrupter shall be installed in deficient practice. a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, How other residents 2. single-phase, 15- and 20-ampere receptacles having the potential to be installed in the locations specified in 210.8(B)(1) affected by the same deficient through (8) shall have ground-fault practice will be identified and circuit-interrupter protection for personnel. what corrective action(s) will (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) be taken? Outdoors, No residents had the potential to (5) Sinks - where receptacles are installed within be affected regarding the deficient 1.8 m (6 ft.) of the outside edge of the sink. practice; however, all staff in the (6) Indoor wet locations, (7) Locker rooms with facility had the potential to be associated showering facilities, (8) Garages, affected, but no employee was. service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. 3. What measures will be NFPA 70, 517-20 Wet Locations, requires all put into place or what systemic receptacles and fixed equipment within the area of changes will be made to the wet location to have GFCI protection. Note: ensure that deficient practice Moisture can reduce the contact resistance of the does not recur? body, and electrical insulation is more subject to The receptacle was immediately failure. This deficient practice could affect staff replaced with a new GFCI outlet

Event ID:

4P7I21 Facility

Facility ID: 000498

If continuation sheet

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11/14/2022

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	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE C	ONSTRUCTION		1B NO. 0938-03 9 SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654			BUILDING WING	01	COMPLETED 10/24/2022	
		R REHABILITATION CENTER	•	2237 E	ADDRESS, CITY, STATE, ZIP COD NGLE RD WAYNE, IN 46809	•	
	1				T		(1/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		ould use the restroom by the			that is in proper working orde	r.	
	dining room.	2					
					4. How will the corrective		
	Findings include:				action(s) be monitored to		
					ensure the deficient practice)	
		on the Maintenance Director			will not recur?		
		45 p.m., there was an electric			ie: what QA program will be		
	_	es from a sink in the restroom by /hen tested with a GFCI tester,			put into place and by what		
	-	not disconnect from power.			date will they be completed.		
	-	at the time of observation, the			All receptacles within 24 inch	es	
		d the electric receptacle did not			from a sink are properly work		
	disconnect from po	-			GFCI receptacles. Only prope	-	
					working GFCI receptacles wil	-	
	-	viewed with the Administrator			installed within 24 inches from	na	
		Director during the exit			sink.		
	conference.						
	3.1-19(b)						
0920	NFPA 101						
SS=E	Electrical Equipm	ent - Power Cords and					
Bldg. 01	Extens						
	Electrical Equipm	ent - Power Cords and					
	Extension Cords						
		patient care vicinity are only					
	used for compone						
		ed electrical equipment bles that have been					
	· · · ·	alified personnel and meet					
		10.2.3.6. Power strips in					
		icinity may not be used for					
		, personal electronics),					
		m care resident rooms that					
		E. Power strips for PCREE					
		or UL 60601-1. Power strips					
		n the patient care rooms					
		y) meet UL 1363. In					
		rooms, power strips meet ds. All power strips are					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 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 10/24/2022 155654 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2237 ENGLE RD FORT WAYNE, IN 46809 **ENGLEWOOD HEALTH & REHABILITATION CENTER** (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 used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 11/09/2022 K920 Electrical Equipment failed to ensure 2 of 2 flexible cords were not used Power Cords and Extension as a substitute for fixed wiring. NFPA-70/2011, Cords 400.8 state unless specifically permitted in 400.7 Plan of Correction flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect 15 residents in kitchen dining 1. What corrective action(s) area and staff in the laundry. will be accomplished for those residents found to have been Findings include: affected by the deficient practice? Based on observation with the Maintenance At the time the deficiency was Director on 10/24/22 at 12:40 p.m., the microwave identified, no residents were found in the kitchen and the air-conditioner in laundry to have been affected by the were plugged into and supplied power by deficient practice. extension cords. Based on interview at the time of observation, the Maintenance Director 2. How other residents acknowledged extension cords were in use and having the potential to be remove the extension cords. affected by the same deficient practice will be identified and The finding was reviewed with the Administrator what corrective action(s) will and Maintenance Director during the exit be taken? conference. All residents in the kitchen dining area, 15 residents total, had the 3.1-19(b) potential to be affected. What measures will be 3. put into place or what systemic changes will be made to ensure that deficient practice does not recur? The extension cord for the 4P7I21 Facility ID: 000498 Page 10 of 11 If continuation sheet

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

Event ID:

11/14/2022

PRINTED:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155654		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			survey leted /2022	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		2237 E	address, city, state, zip cod NGLE RD WAYNE, IN 46809	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
					microwave and the extension for the air conditioner were immediately removed.	cord	
					4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? ie: what QA program will be put into place and by what date will they be completed.	e	
					No extension cords will be us as a substitute for fixed wiring structure.		

Facility ID: 000498

If continuation sheet

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