STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155798	A. BUILDING 01 B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 10/20/22 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 12/12/22 Facility Number: 012861 Provider Number: 155798 AIM Number: 201080610 At this PSR survey, Ashton Creek Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 139 and had a census of 102 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/19/22	K 0000	This plan of correction is the center's credible allegation of compliance. 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 and/or executed soley because it is required by the provisions of federal and state law. We respectfully request paper compliance for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Molly Linder	Administrator	01/03/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 10 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 30 residents in the dining room. Findings include: Based on an observation with the Maintenance Director on 12/12/22 at 1:55 p.m., the exit hall from the dining room to the rear exit contained 20 boxes and totes protruding into the corridor about two feet. Based on an interview at the time of observations, the Maintenance Director agreed 20 boxes and totes were stored in the corridor and obstructing the path of egress to the exit door. The finding was reviewed with the Maintenance Director during the exit conference. This tag was cited on 10/20/22. Although the original citing was corrected, the facility failed to implement a systemic plan to prevent recurrence of deficiencies for all Means of Egress requirements. 3.1-19(b)	K 0211	Corrective action for affected residents: 1. The 20 boxes and totes were removed from the exit hall from the dining room to the rear exit. How other residents have the potential to be affected: 2. Up to 30 residents in the dining room have the potential to be affected by the alleged deficient practice. Measures put into place and systematic changes: 3. An audit will be completed daily for 6 weeks, 3 times a week for 3 weeks and weekly until 100% compliant. How the corrective action will be monitored: 4. Results of this audit will be forwarded to the Quality Assurance Committee for review	12/31/2022

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			monthly for 6 months with a goal with of 100% comliance. Once 100% compliance is achieved frequency of further review will be determined by the QAPI committee. Date systemic changes will be completed: 5. Systemic changes for deficiency will be completed by 12/31/22	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility	K 0324	Corrective action for affected	12/31/2022

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	failed to maintain 1 of 4 kitchen corridor doors to ensure cooking facilities that serve 30 or more residents were not open to the corridor. This deficient practice affects 50 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 12/12/22 at 1:50 p.m., the main kitchen which serve 30 or more residents was open to the corridor due to one of the kitchen corridor doors was blocked from closing because a cart was in front of the door. Based on interview at the time of the observations, the Maintenance Director agreed a kitchen door was blocked from closing. The finding was reviewed with the Maintenance Director during the exit conference. This deficiency was cited on 10/20/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		residents: 1. Door was immediately shut and cart was removed. Magnetic release devices were installed on kitchen doors on 12/20/22. How other residents have the potential to be affected: 2. How other residents have the potential to be affected: Up to 50 residents in 1 smoke compartment have the potential to be affected by the alleged deficient practice. Measures put into place and systematic changes: 3. An audit will be completed daily for 6 weeks, 3 times a week for 3 weeks and weekly until 100% compliant. How the corrective action will be monitored: Results of this audit will be forwarded to the quality Committee for review montly for 6 months with a goal of 100% compliance. Once 100% compliance is achieved frequency of further review will be determined by the QAPI committee. Date systemic changes will be completed:	

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			5 Systemic changes for deficiiency will be completed by 12/31/22	