STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING -- B. WING	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/06/24 Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740 At this Emergency Preparedness survey, Life Care Center of Fort Wayne was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 125 and had a census of 79 at the time of this survey. Quality Review completed on 06/19/24	E 0000		
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Holly Gentry	Executive Director	07/01/2024

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

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	155266	A. BUILDING -- B. WING	06/06/2024

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	§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS			

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	155266	A. BUILDING -- B. WING	06/06/2024

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	Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition,			

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	including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 06/06/24 at 10:02 a.m., the generator lacked diesel fuel testing required by LSC and NFPA 110. Based on an interview at the time of record review, the Maintenance Director stated the generator was missing the diesel fuel testing. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **E041 Hospital CAH and LTC Emergency Power** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The Maintenance Director contacted vendor immediately upon identification with annual fuel quality test completed on 6/6/2024. ***How other residents having the potential to be affected by the same deficient practice will be***	07/05/2024

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			identified and what corrective action will be taken: All residents and staff have the potential to be affected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** The process for maintenance and performance of the annual fuel quality test was added to the TELS Preventative Maintenance schedule. Any identified issues will be immediately addressed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024. The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000		

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/06/24 Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740 At this Life Safety Code survey, Life Care Center of Fort Wayne 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 III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 125 and had a census of 79 at the time of this survey All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance office/workshop/storage building. Quality Review completed on 06/19/24			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in			

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	accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 2 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 20 residents in the memory care unit. Findings include: Based on observations with the Maintenance Director and Administrator during a tour of the facility on 06/06/2024 at 11:56 a.m., the memory care unit contained an exterior door which was not an exit and could be mistaken as an exit did not have a "NO EXIT" sign posted. Based on interview at the time of observation, the Maintenance Director stated the door was not an exit and agreed a "NO EXIT" sign was not posted. This finding was reviewed with the Maintenance Director and Administrator at the time of the exit conference. 3.1-19(b)	K 0293	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K293 Exit Signage** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** "NO EXIT" signage was purchased and posted on the exterior door on memory care unit.	07/05/2024

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			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents and staff have the potential to be affected. Audit was completed of all other exterior doors any identified issues were corrected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Education was provided to maintenance staff related to ensuring doors to the outside of facility were not mistaken as a facility exit. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the identified exterior doors 1x per month for 6 months to ensure compliance is achieved. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does	

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			not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 manual pull stations in the kitchen met the requirement of LSC 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use, whereas NFPA 72, 2010 Edition section 17.14.4 states the operable part of each manual fire alarm box shall be not less than 42 in. (1.07 m) and not more than 48 in. (1.22 m) above floor level. This deficient practice could	K 0341	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible	07/05/2024

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	affect staff and 40 residents in the dining room. Findings include: Based on observations with the Maintenance Director and Administrator during a tour of the facility on 06/06/2024 at 11:18 a.m. the fire alarm manual pull station in the kitchen was mounted 62 inches above the floor to the bottom of the pull station as measured with a tape measure. Base on interview during observation, the Maintenance Director observed the measurement at that time and agreed the measurement was 62 inches. This finding was reviewed with the Maintenance Director and Administrator at the time of the exit conference. 3.1-19(b)		allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K341 Fire Alarm System – Installation** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Vendor was scheduled and the manual pull station in facility kitchen was lower to be within regulation height. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents and staff have the potential to be affected. Audit was completed of all other manual pull stations with any identified issues were corrected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Education was provided to maintenance staff to ensure understanding and importance of K341 regulation. ***How the corrective action will***	

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			be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Executive Director and/or designee will conduct audits of the facility manual pull stations 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and 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, 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			

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	Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 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 accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals. b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director on 06/06/24 at 10:25 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 04/20/24. Based on an interview at the time of records review, the Maintenance Director stated a visual inspection of the fire alarm system six months prior to annual fire alarm inspection was not conducted. The finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0345	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. K345 Fire Alarm System – Testing and Maintenance What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: Visual annual inspection of the fire alarm system was completed on May 20, 2024. Semi Annual was added to our contract with VFP for a date set in November 2024 for the semi annual inspection. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:	07/05/2024

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			All residents and staff have the potential to be affected. What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur: The visual inspection of the semi annual fire alarm system was added to the TELS Preventive Maintenance schedule with education provided to maintenance staff to ensure understanding and importance of conducting inspections for staff and resident safety. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in	

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LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN 46805

(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
			ensuring compliance in this Plan of Correcti	
K 0355 SS=B Bldg. 01	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 ensure 2 of 20 fire extinguishers met the requirements of LSC 9.7.4.1 which states where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 section 7.2.1.2 states Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director and Administrator during a tour of the facility on 06/06/2024 (1) at 11:15 a.m. the fire extinguisher in the service corridor outside the kitchen was not inspected since April of 2024, and (2) at 11:39 a.m. the fire extinguisher in the corridor near the oxygen room had not been inspected since April 2024. Based on interview during observation, the Maintenance Director stated the two extinguishers were not inspected last month. This finding was reviewed with the Maintenance Director and Administrator at the time of the exit	K 0355	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K355 Portable /Fire Extinguishers** ***What Corrective Action will be accomplished for those residents found to have been***	07/05/2024

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	155266	A. BUILDING 01 B. WING	06/06/2024

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	conference. 3.1-19(b)		***affected by this deficient practice:*** Upon identification the fire extinguishers were immediately manually inspected. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents and staff have the potential to be affected. Audit was completed of all facility fire extinguishers with any identified issues corrected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance was educated on importance of timely conducting the manual fire extinguisher inspection as per regulation for staff and resident safety. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's fire extinguishers 1x per month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction	

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			developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors			

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	meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 2 Beecher dining room double doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 20 residents in the Beecher dining room. Findings include: Based on observation with the Maintenance Director and Administrator on 04/06/24 at 12:13 p.m., the corridor double doors to the back of the Beecher dining room did not latch into the frame when tested. Based on an interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame when tested. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K363 Corridor Doors**	07/05/2024

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			What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice: The corridor double doors to the back of the Beecher dining room was repaired so it would now latch into the frame. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents and staff have the potential to be affected. Audit was completed of all facility doors to ensure they appropriately latch into the frame. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance staff was educated on K363. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's doors 1x per week for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with	

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			subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric 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 failed to ensure 1 of 1 electrical junction boxes in the space above the drop ceiling was maintained in a safe operating condition. LSC 19.5.1.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3)(c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0511	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to	07/05/2024

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	Based on observations with the Maintenance Director during a tour of the facility on 6/06/2024 at 12:33 p.m., an electrical junction box in the space above the drop ceiling in the corridor between rooms 31 and 32 was not provided with a cover plate and had exposed electrical wiring. Based on interview at the time of the observations, the Maintenance Director acknowledged the electrical junction box was not provided with a cover and had exposed wires. This finding was reviewed with the Maintenance Director and Administrator at the time of the exit conference. 3.1-19(b)		remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K511 Utilities – Gas and Electric** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Upon identification a cover plate was installed on the junction box in the space above the drop ceiling in the corridor between rooms 31 and 32. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All residents and staff have the potential to be affected. Audit was completed of all facility junction boxes to ensure a cover plate was in place and no electrical wiring exposed. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance staff was educated on K511. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:***	

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			Executive Director and/or designee will conduct audits of 5 junction boxes 1x per week for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies			

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	are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 61 resident room doors met the requirement of LSC 19.7.5.6(4)(c) which prohibits combustible decorations from covering more than 30 percent of a non-fire rated door. This deficient practice could affect two residents. Findings include: Based on observations with the Maintenance Director and Administrator on 06/06/2024 at 11:27 a.m., the door to resident room 42 was more than 30 percent covered in combustible paper art. Based on interview during observation. The Administrator agreed the decorations covered more than 30 percent of the door and stated they will discuss this with the resident. This finding was reviewed with the Maintenance Director and Administrator at the time of the exit conference. 3.1-19(b)	K 0753	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K753 Combustible Decorations** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Upon identification, the combustible decorative paper art was removed from resident room door for room #42. ***How other residents having the potential to be affected by the same deficient practice will be***	07/05/2024

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			identified and what corrective action will be taken: All residents and staff have the potential to be affected. Audit was completed of the facility doors to ensure the combustible decorations were 30% or less on doors. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance staff was educated on K753. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of 5 facility doors 1x per week for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan	

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			of Correction.	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.	K 0761	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K761 Maintenance, Inspection & Testing - Doors** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Upon review of all facility inspection reports, it was identified the annual fire door inspections were completed on 11/8/2023.	07/05/2024

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	(4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director on 06/06/24 at 10:19 a.m., documentation of the annual inspection for the five fire door assemblies were not available for review. Based on observation during the tour between 11:30 a.m. and 1:00 p.m., there were five fire door assemblies with a one-and-a-half-hour rating label. Based on an interview at the time of records review and observation, the Maintenance Director agreed the facility contained 5 fire doors and stated the annual fire door inspections were not completed within the last year. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** No staff or residents were affected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance staff was re-educated on fire door inspection as well as properly organizing and keeping facility inspection reports/documentation. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's inspection reports 1x per month for 6 months to ensure compliance and proper documentation is available. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The	

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			Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design			

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(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
	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review, observation, and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on a records review with the Administrator and the Maintenance Director on 06/06/24 at 10:00 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on observation at 12:00 p.m., the facility had a diesel-powered generator in the parking lot. Based on interview at the time of records review and observation, the Administrator stated the facility did have a diesel fuel quality test in June of 2023 but could not find the paperwork. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0918	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K918 Electrical Systems Essential Electric System Maintenance/Testing** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The Maintenance Director contacted vendor immediately upon identification with annual fuel quality test completed on 6/6/2024.	07/05/2024

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	155266	A. BUILDING 01 B. WING	06/06/2024

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			How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents and staff have the potential to be affected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** The process for maintenance and performance of the annual fuel quality test was added to the TELS Preventative Maintenance schedule. Any identified issues will be immediately addressed. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024. The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	

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K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are 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 failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observations with the Maintenance Director and Administrator on 06/06/2024 at 12:10 p.m., a power-strip in room 35 was in use within 6 feet of a resident care area that did not meet	K 0920	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate	07/05/2024

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	1363A or 60601-1. The power strip had a label stating it "CONFORMS TO UL STD 1363". Based on interview during observation. The Administrator agreed the power strip did not meet UL 1363A or 60601-1. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K920 Electrical Equipment – Power cords and Extenstions** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** Power strip was immediately removed. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** All other residents and staff have potential to be affected. Full facility audit was completed to ensure all in use power strips meet regulation. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance staff were educated on power strip use. ***How the corrective action will be monitored to ensure the deficient practice will not recur,***	

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			i.e., what quality assurance program will be put in place: Executive Director and/or designee will conduct audits of 5 rooms 1x per week for 6 months to ensure compliance related to use of power strips. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan of Correction.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with			

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	conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms met the requirement of NFPA 99, 2012 Edition Section 9.3.7 Medical Gas Storage or Transfilling and Section 9.3.7.5.3.1 states mechanical exhaust to maintain a negative pressure in the space shall be provided continuously, unless an alternative design is approved by the authority having jurisdiction. This deficient practice could affect 30 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Administrator on 06/06/2024 at 11:38 a.m., the exhaust fan in the oxygen storage and transfilling room was not functioning and failed to create a negative pressure in the room. Based on interview during observation, the Maintenance Director agreed the exhaust fan was not working. This finding was reviewed with the Maintenance Director and Administrator at the time of the exit conference. 3.1-19(b)	K 0927	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Fort Wayne agrees with the allegations and citations listed. Life Care Center of Fort Wayne maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review. **K927 Gas Equipment – Transfilling Cylinders** ***What Corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** The exhaust fan in the oxygen storage/transfilling room was repaired. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective***	07/05/2024

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			action will be taken: No other staff or residents were affected. ***What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:*** Maintenance staff was educated on inspection of the facility exhaust fans, as well as monitoring frequency schedule in TELS was increased for the exhaust fans to weekly. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** Executive Director and/or designee will conduct audits of the facility's exhaust fans 1x per week for 6 months to ensure compliance and proper documentation is available. Any issues identified will be immediately addressed. The above stated audit results and system components will be reviewed by the QAPI Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in ensuring compliance in this Plan	

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