PRINTED: 07/03/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED
		155266	B. WING		- 06/06/2024
	PROVIDER OR SUPPLIER		1649	ET ADDRESS, CITY, STATE, ZIP CO O SPY RUN AVENUE RT WAYNE, IN 46805	D
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI	ection (X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		OULD BE COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	conducted by the In accordance with 42 Survey Date: 06/06 Facility Number: 06 Provider Number: 1 AIM Number: 1002 At this Emergency Care Center of Fort substantial complia Preparedness Require Medicaid Participat CFR 483.73. The fa had a census of 79 and 12 for the substantial compliant of the substantial	5/24 00167 55266	E 0000		
E 0041 SS=C Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power sys- emergency plan is this section and in procedures plan is (i) and (ii) of this is §483.73(e), §485. (e) Emergency and The [LTC facility as implement emerge- systems based or	LTC Emergency Power tion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE

(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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155266		A. BUILDING B. WING		COMPLETED 06/06/2024				
	OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1649 SPY RUN AVENUE					
LIFE (	CARE CENTER OF FO	ORT WAYNE	FORT	WAYNE, IN 46805	<u>,                                      </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Emergency gener generator must be the location required Care Facilities Counterim Amendments TIA and TIA 12-4), and structure is built of structure or building the lospital, CA implement the eminspection, testing requirements four Facilities Code, Normal Code.  482.15(e)(3), §48 Emergency generation the eminspection, testing requirements four Facilities Code, Normal Code.  482.15(e)(3), §48 Emergency generation and LTC facilities source to power end LTC facilities so	3.73(e)(2), §485.625(e)(2) rator inspection and testing. H and LTC facility] must nergency power system g, and [maintenance] nd in the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3) rator fuel. [Hospitals, CAHs ] that maintain an onsite fuel emergency generators must ow it will keep emergency perational during the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED  B. WING 06/06/2024				
		155266	B. W	ING		06/06/	2024
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LIEE CAT	RE CENTER OF FO	DT MAVNE			PY RUN AVENUE		
LIFE CAI	TE CENTER OF FO	UNI WATINE		FURIV	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION urce Center, 7500 Security		TAG	DE IOLEKO I		DATE
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
	, ,	ARA, call 202-741-6030, or					
	go to:						
		es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a Federal Register to					
	announce the cha	_					
		Protection Association, 1					
	Batterymarch Parl						
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.						
		th Care Facilities Code,					
		ed August 11, 2011.					
	` '	im amendment (TIA) 12-2 to					
	NFPA 99, issued	August 11, 2011. FPA 99, issued August 9,					
	2012.	-FA 99, Issued Adgust 9,					
	-	FPA 99, issued March 7,					
	2013.	,					
	(v) TIA 12-5 to NF	PA 99, issued August 1,					
	2013.						
	' '	FPA 99, issued March 3,					
	2014.						
	' '	fe Safety Code, 2012					
	edition, issued Au	IFPA 101, issued August					
	11, 2011.	arr A 101, issued August					
		FPA 101, issued October					
	30, 2012.						
	(x) TIA 12-3 to NF	PA 101, issued October					
	22, 2013.						
	` '	FPA 101, issued October					
	22, 2013.	Mandaud fan Fransisser					
		standard for Emergency and ystems, 2010 edition,					

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Event ID:

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DEPARTMENT	OF HEALTH AND HUMAN SERVICES	
CENTERS FOR	MEDICARE & MEDICAID SERVICES	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED	
		155266	B. W	NG _		06/06/2024		
			I	CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	L.			PY RUN AVENUE			
	RE CENTER OF FC							
LIFE CAP	RE CENTER OF FC	ORI WATNE		FURI	WAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	including TIAs to a 2009	chapter 7, issued August 6,						
	l e	view and interview, the facility	E 00	041	This plan of correction is prepa	arad	07/05/2024	
		the emergency power system		J <del>4</del> 1	and executed because the	al eu	07/03/2024	
		in the Health Care Facilities			provisions of state and federal	low		
	_	nd Life Safety Code in			require it and not because Life			
		CFR 483.73(e)(2). This			Care Center of Fort Wayne ag			
		ould affect all occupants.			with the allegations and citatio			
	deficient practice of	sala alleet all occupants.			listed. Life Care Center of Fort			
	Findings include:				Wayne maintains that the alleg			
	rindings include.				deficiencies do not jeopardize			
	Rased on records re	view with the Administrator			health and safety of the reside			
		irector on 06/06/24 at 10:02			nor is it of such character to lir			
		lacked diesel fuel testing			our capabilities to render adeq			
	_	d NFPA 110. Based on an			care. Please accept this plan of			
		e of record review, the			care. Flease accept this plant	"		
		or stated the generator was			allegation of compliance that the			
	missing the diesel fi							
	illissing the dieser it	uer testing.			alleged deficiencies have or w			
	The finding was rev	riewed with the Administrator			correct by the date indicated to			
		irector at the exit conference.			remain in compliance with stat			
	and Maintenance D	nector at the exit conference.			and federal regulations, the factors has taken or will take the action	-		
					set forth in this plan of correcti			
					1 · · · · · · · · · · · · · · · · · · ·			
					We respectfully request a desireview.	`		
					E041 Hospital CAH and LTC			
					Emergency Power What Corrective Action will be	,		
						, <del>c</del>		
					accomplished for those residents found to have been	,		
						<b>'</b>		
					affected by this deficient			
					practice: The Maintenance Director			
					contacted vendor immediately	fuel		
					upon identification with annual	iuei		
					quality test completed on			
					6/6/2024.			
					How other residents having to			
					potential to be affected by th			
					same deficient practice will b	e		
	•				•			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155266		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURV  COMPLETED  06/06/2024					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1649 SPY RUN AVENUE FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				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 performance of the annual fue quality test was added to the TELS Preventative Maintenant schedule. Any identified issue will be immediately addressed. How the corrective action who be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put in place. The above stated audit results system components will be reviewed by the QAPI Commi on a monthly basis with subsequent plans of correction developed and implemented addeemed necessary. At that tin analysis of data will be done to ensure the deficient practice of not reoccur and/or adapt audit schedules.  Compliance date: 7/5/2024. The Administrator at Life Care Cerof Fort Wayne is responsible in ensuring compliance in this Plof Correction.	e  ade  and el  ace s l. iiii  cur, s and ttee  n as ne, o does t  he nter n		
K 0000							
Bldg. 01	A Life Safety Code	Recertification and State	K 0000				

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Facility ID: 000167

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155266		(X2) MULTIPI A. BUILDIN B. WING		istruction <u>01</u>	(X3) DATE ( COMPL 06/06/	ETED	
	PROVIDER OR SUPPLIER		164	9 SP	DDRESS, CITY, STATE, ZIP COD Y RUN AVENUE AYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	-	ras conducted by the Indiana th in accordance with 42 CFR					
	Survey Date: 06/06	5/24					
	Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740						
	of Fort Wayne was Requirements for Post Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (L	Code survey, Life Care Center found not in compliance with articipation in 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, asC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	Type III (200) cons sprinklered. The fa with smoke detection to the corridors and detectors in the resi	ity was determined to be of truction and was fully cility has a fire alarm system on in the corridors, areas open battery operated smoke dent rooms. The facility has a had a census of 79 at the time					
	access were sprinkle facility services were	residents have customary ered. All areas providing re sprinklered, except a workshop/storage building.					
	Quality Review con	npleted on 06/19/24					
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directiona	al signs are displayed in					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155266	B. W	NG	06/06/202		/2024
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			PY RUN AVENUE		
LIFE CAI	RE CENTER OF FO	ORT WAYNE			WAYNE, IN 46805		
				TOKT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		7.10 with continuous					
		erved by the emergency					
	lighting system.						
	19.2.10.1						
	(Indicate N/A in or	-					
	·	less than 30 occupants					
		exit travel is obvious.)	77. ^	202			07/05/2024
		on and interview, the facility	K 0	293	This plan of correction is prepared	ared	07/05/2024
		f 2 doors to the outside of the			and executed because the		
		istaken as a facility exit. LSC			provisions of state and federal		
		y door, passage, or stairway			require it and not because Life		
	that is neither an exit nor a way of exit access and				Care Center of Fort Wayne ag		
	that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign				with the allegations and citation listed. Life Care Center of For		
		rs: NO EXIT. The NO EXIT			Wayne maintains that the allege		
		word NO in letters 2 inches			deficiencies do not jeopardize	-	
	_	width of 3/8ths inch, and the			health and safety of the reside		
	-	the word NO, unless such sign			nor is it of such character to lin		
		ting sign. This deficient			our capabilities to render adec		
		et 20 residents in the memory			care. Please accept this plan	-	
	care unit.	to 20 residents in the memory			correction as our credible	51	
	Cure unit.				allegation of compliance that t	he	
	Findings include:				alleged deficiencies have or w		
					correct by the date indicated to		
	Based on observation	ons with the Maintenance			remain in compliance with sta		
		nistrator during a tour of the			and federal regulations, the fa		
		024 at 11:56 a.m., the memory			has taken or will take the action	-	
	-	an exterior door which was not			set forth in this plan of correct		
	an exit and could be	e mistaken as an exit did not			We respectfully request a des		
	have a "NO EXIT"	sign posted. Based on			review.		
	interview at the tim	e of observation, the			_		
	Maintenance Direct	tor stated the door was not an			K293 Exit Signage		
	exit and agreed a "I	NO EXIT" sign was not posted.			What Corrective Action will I	be	
					accomplished for those		
	This finding was re	viewed with the Maintenance			residents found to have been	n	
	Director and Admir	nistrator at the time of the exit			affected by this deficient		
	conference.				practice:		
					"NO EXIT" signage was purch		
	3.1-19(b)				and posted on the exterior do	or on	
					memory care unit.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155266	B. WING		06/06	/2024	
			CTREET	ADDRESS CITY STATE TIP COD			
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD			
LIEE CAE	RE CENTER OF FO			PY RUN AVENUE WAYNE, IN 46805			
LIFE CAP	RE CENTER OF FO	JRT WATNE	FORT				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				How other residents having t	he		
				potential to be affected by the	е		
				same deficient practice will b	е		
				identified and what corrective	е		
				action will be taken:			
				All residents and staff have the	9		
				potential to be affected. Audit v	was		
				completed of all other exterior			
				doors any identified issues we	re		
				corrected.			
				What measures and what			
				systemic changes will be ma	de		
				to ensure that the deficient			
				practice doesn't recur:			
				Education was provided to			
				maintenance staff related to			
				ensuring doors to the outside of	of		
				facility were not mistaken as a			
				facility exit.			
				How the corrective action will	II .		
				be monitored to ensure the			
				deficient practice will not rec	ur,		
				i.e., what quality assurance			
				program will be put in place:			
				Executive Director and/or	_		
				designee will conduct audits of			
				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 Commit	tee		
				on a monthly basis with			
				subsequent plans of correction			
				developed and implemented a			
				deemed necessary. At that tim	e,		

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analysis of data will be done to ensure the deficient practice does

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EPARTMENT OF HEALTH AND HUMAN SERVICES							
ENTERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. 093				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY				
AND DE AN OF CORRECTION	IDENTIFICATION AND ODER	A DIMEDDIG 04	COLUMN EXTEN				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155266		A. BUILDING B. WING	01	COMPLE 06/06/2	TED	
	PROVIDER OR SUPPLIER		1649 S	ADDRESS, CITY, STATE, ZIP COD SPY RUN AVENUE WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
				not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, T Administrator at Life Care Cer of Fort Wayne is responsible i ensuring compliance in this Pl of Correction.	he nter n	
K 0341 SS=E Bldg. 01	and components a accordance with N Code, and NFPA Code to provide e part of the building occupied, detection alarm control unit detection is also in appliance circuit p supervising statio Fire alarm system transmission path integrity.  18.3.4.1, 19.3.4.1 Based on observation failed to ensure 1 okitchen met the requalarm system requires	n - Installation m is installed with systems approved for the purpose in NFPA 70, National Electric 72, National Fire Alarm iffective warning of fire in any g. In areas not continuously on is installed at each fire in new occupancy, installed at notification bower extenders, and in transmitting equipment. In wiring or other is are monitored for	K 0341	This plan of correction is prep and executed because the provisions of state and federa require it and not because Life Care Center of Fort Wayne ag	l law	07/05/2024
	National Electrical Fire Alarm and Sig approved existing i permitted to be con 72, 2010 Edition se part of each manual than 42 in. (1.07 m)	requirements of NFPA 70, Code, and NFPA 72, National naling Code, unless it is an nstallation, which shall be tinued in use, whereas NFPA ction 17.14.4 states the operable I fire alarm box shall be not less and not more than 48 in. (1.22)		with the allegations and citatic listed. Life Care Center of For Wayne maintains that the alle deficiencies do not jeopardize health and safety of the reside nor is it of such character to lit our capabilities to render adec care. Please accept this plan correction as our credible	t ged the ents mit quate	

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155266	B. W	ING		06/06/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			PY RUN AVENUE		
LIFE CAI	RE CENTER OF FO	ORT WAYNE			WAYNE, IN 46805		
		JKI WATNE		TOKT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	affect staff and 40 i	residents in the dining room.			allegation of compliance that t		
					alleged deficiencies have or w		
	Findings include:				correct by the date indicated t		
					remain in compliance with sta		
		ons with the Maintenance			and federal regulations, the fa	-	
		nistrator during a tour of the			has taken or will take the action		
	1	024 at 11:18 a.m. the fire alarm			set forth in this plan of correct		
	_	in the kitchen was mounted 62			We respectfully request a des	k	
		oor to the bottom of the pull			review.		
		l with a tape measure. Base on			-		
		oservation, the Maintenance			K341 Fire Alarm System –		
		the measurement at that time			<u>Installation</u>		
	and agreed the mea	surement was 62 inches.			What Corrective Action will	be	
					accomplished for those		
		eviewed with the Maintenance			residents found to have been	n	
		nistrator at the time of the exit			affected by this deficient		
	conference.				practice:		
	2.1.10(1)				Vendor was scheduled and th	е	
	3.1-19(b)				manual pull station in facility		
					kitchen was lower to be within		
					regulation height.		
					How other residents having		
					potential to be affected by the		
					same deficient practice will identified and what corrective		
					action will be taken:	e	
					All residents and staff have the	•	
					potential to be affected. Audit		
					completed of all other manual		
					stations with any identified iss	•	
					were corrected.	403	
					What measures and what		
					systemic changes will be ma	ade	
					to ensure that the deficient		
					practice doesn't recur:		
					Education was provided to		
					maintenance staff to ensure		
					understanding and importance	e of	
					K341 regulation.		
					How the corrective action w	ill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED		
		155266	B. W		<del> </del>	06/06/	
	ROVIDER OR SUPPLIER		•	1649 SF	ADDRESS, CITY, STATE, ZIP COD PY RUN AVENUE VAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ON SHOULD BE COMPLE HE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	be monitored to ensure the deficient practice will not redice., what quality assurance program will be put in place: Executive Director and/or designee will conduct audits of facility manual pull stations 1x month for 6 months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results system components will be reviewed by the QAPI Committon a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that time analysis of data will be done to ensure the deficient practice of not reoccur and/or adapt audit schedules.  Compliance date: 7/5/2024, TI Administrator at Life Care Cere of Fort Wayne is responsible in ensuring compliance in this Plant.	f the per fied	DATE
					of Correction.		
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr	n - Testing and m is tested and maintained n an approved program requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.					

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Event ID:

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Facility ID: 000167

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155266	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/06/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1649 SPY RUN AVENUE FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Based on record reversal failed to maintain 1 accordance with NI Sections 19.3.4.5.1 14.3.1 states that ur 14.3.2, visual insperance often if requiring jurisdiction. Table must be visually instance and the more often if requiring a. Control unit troub. Remote annunciate. Initiating devices fire alarm boxes, he etc.)  d. Notification applete. Magnetic hold-operance facility.  Findings include:  During records reversal price of the finding was reversal inspection of the finding prior to the annual on 04/20/24. Based records review, the visual inspection of months prior to annual conducted.  The finding was reversal accordance of the finding was reversal for the finding was reversal for the finding was reversal findi	view and interview, the facility of 1 fire alarm systems in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by ctions shall be performed in the schedules in Table 14.3.1, or are by the authority having 14.3.1 states that the following spected semi-annually: ble signals.  Intors is (e.g. duct detectors, manual cent detectors, smoke detectors, itances pen devices ice affects all occupants in the sew with the Maintenance	KO	345	This plan of correction is prepand executed because the provisions of state and federal require it and not because Lift Care Center of Fort Wayne as with the allegations and citated listed. Life Care Center of Fort Wayne maintains that the allegation stated deficiencies do not jeopardize health and safety of the residencies it of such character to lift our capabilities to render adecare. Please accept this plan correction as our credible allegation of compliance that alleged deficiencies have or worrect by the date indicated remain in compliance with states and federal regulations, the fathas taken or will take the activate forth in this plan of correct We respectfully request a describing with the accomplished for those reside found to have been affected by deficient practice:  Visual annual inspection of the alarm system was completed May 20, 2024. Semi Annual wadded to our contract with VF a date set in November 2024 the semi annual inspection. How other residents having the potential to be affected by the same deficient practice will be same deficient practice.	al law e grees ons t eged e the ents mit quate of the vill be to acility ons tion. sk esting e ents on vas P for for	07/05/2024

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Event ID: 9S4U21

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action will be taken:

identified and what corrective

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CENTERS FOI	OMB NO. 0938-039						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155266	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/06/2024		
NAME OF 1	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 1649 SPY RUN AVENUE				
LIFE CA	RE CENTER OF F	ORT WAYNE	FORT				
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	All residents and staff have the potential to be affected. What measures and what systemic changes will be made ensure that the deficient practice doesn't recur: The visual inspection of the seannual fire alarm system was added to the TELS Preventive. Maintenance schedule with education provided to maintestaff to ensure understanding importance of conducting inspections for staff and residual safety. How the corrective action will monitored to ensure the deficient practice will not recur, i.e., who quality assurance program with put in place: Executive Director and/or designee will conduct audits of facility's inspection reports 1x month for 6 months to ensure compliance. Any issues ident will be immediately addressed the above stated audit result system components will be reviewed by the QAPI Common a monthly basis with subsequent plans of correction developed and implemented deemed necessary. At that ting analysis of data will be done the ensure the deficient practice and recocur and/or adapt and	de to tice emi e nance and dent be ient int itle iffied d. s and ittee on as me, to does	DATE	

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Facility ID: 000167

schedules.

If continuation sheet

Compliance date: 7/5/2024, The Administrator at Life Care Center of Fort Wayne is responsible in

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STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155266	B. WI	NG		06/06/	/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					PY RUN AVENUE		
LIFE CAP	RE CENTER OF FC	ORT WAYNE		FORT	VAYNE, IN 46805		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					ensuring compliance in this Pla	an	
					of Correcti		
K 0355	NFPA 101						
SS=B	Portable Fire Extir	nguishers					
Bldg. 01	Portable Fire Extinguishers						
		guishers are selected,					
		d, and maintained in					
	-	IFPA 10, Standard for					
	Portable Fire Extir						
	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						
			K 0.	355	This plan of correction is prepa	ared	07/05/2024
			K 0333		and executed because the		
		© 9.7.4.1 which states where			provisions of state and federal law		
		visions of another section of			require it and not because Life		
		fire extinguishers shall be			Care Center of Fort Wayne agrees		
	selected, installed, i	nspected, and maintained in			with the allegations and citations		
		FPA 10, Standard for Portable			listed. Life Care Center of Fort		
	Fire Extinguishers.	NFPA 10 section 7.2.1.2 states			Wayne maintains that the alleg	ged	
	Fire extinguishers s	hall be inspected either			deficiencies do not jeopardize	_	
	manually or by mea	ns of an electronic monitoring			health and safety of the reside		
		ninimum of 30-day intervals.			nor is it of such character to lir		
	This deficient practi	ice could affect 40 residents in			our capabilities to render adeq	luate	
	two smoke compart	ments.			care. Please accept this plan of	of	
					correction as our credible		
	Findings include:				allegation of compliance that t	he	
					alleged deficiencies have or w	ill be	
	Based on observation	ons with the Maintenance			correct by the date indicated to	<b>o</b>	
	Director and Admin	istrator during a tour of the			remain in compliance with stat	ie .	
	facility on 06/06/20	24 (1) at 11:15 a.m. the fire			and federal regulations, the fa		
	extinguisher in the s	service corridor outside the			has taken or will take the actio	-	
	kitchen was not insp	pected since April of 2024, and			set forth in this plan of correcti	on.	
	(2) at 11:39 a.m. the	e fire extinguisher in the corridor			We respectfully request a desl		
		m had not been inspected			review.		
	since April 2024. B	ased on interview during			_		
	_	intenance Director stated the			K355 Portable /Fire		
		vere not inspected last month.			<u>Extinguishers</u>		
		•			What Corrective Action will be	ре	
	This finding was rev	viewed with the Maintenance			accomplished for those		
		istrator at the time of the exit			residents found to have been	า	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155266	B. W	ING		06/06	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			PY RUN AVENUE		
LIEE CAE	RE CENTER OF FO	DT WAYNE			WAYNE, IN 46805		
LII L OAI	· · · · · · · · · · · · · · · · · · ·	JKI WATNE		TORT			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conference.				affected by this deficient		
					practice:		
	3.1-19(b)				Upon identification the fire		
					extinguishers were immediate	ly	
					manually inspected.		
					How other residents having		
					potential to be affected by the		
					same deficient practice will		
					identified and what corrective	⁄e	
					action will be taken:		
					All residents and staff have th		
					potential to be affected. Audit	was	
					completed of all facility fire		
					extinguishers with any identific	ed	
					issues corrected.		
					What measures and what		
					systemic changes will be ma	ade	
					to ensure that the deficient		
					practice doesn't recur:		
					Maintenance was educated or		
					importance of timely conducting	ng	
					the manual fire extinguisher		
					inspection as per regulation for	or	
					staff and resident safety.		
					How the corrective action w	ill	
					be monitored to ensure the		
					deficient practice will not red	cur,	
					i.e., what quality assurance		
					program will be put in place.	:	
					Executive Director and/or	• • •	
					designee will conduct audits of		
					facility's fire extinguishers 1x		
					month for 6 months to ensure		
					compliance. Any issues identi		
					will be immediately addressed		
					The above stated audit results	s and	
					system components will be		
					reviewed by the QAPI Commi	ttee	

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on a monthly basis with subsequent plans of correction

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155266	B. W	ING	_	06/06/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		1649 SF	PY RUN AVENUE		
LIFE CAF	RE CENTER OF FC	ORT WAYNE		FORT V	VAYNE, IN 46805		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					developed and implemented a deemed necessary. At that tim		
					analysis of data will be done to		
					ensure the deficient practice d		
					not reoccur and/or adapt audit		
					schedules.		
					Compliance date: 7/5/2024, Th	ne	
					Administrator at Life Care Cen		
					of Fort Wayne is responsible i	า	
					ensuring compliance in this Pl	an	
	of Correction.						
K 0363	NFPA 101						
SS=E	Corridor - Doors						
Bldg. 01	Corridor - Doors						
		corridor openings in other					
		osures of vertical openings,					
	-	s areas resist the passage					
	of smoke and are	made of 1 3/4 inch					
	solid-bonded core	wood or other material					
	capable of resistin	g fire for at least 20					
		fully sprinklered smoke					
		only required to resist the					
	-	e. Corridor doors and doors					
	to rooms containin	_					
		rials have positive latching					
		atches are prohibited by					
	-	hese requirements do not spaces that do not contain					
	flammable or com	•					
		n bottom of door and floor					
		ceeding 1 inch. Powered					
	-	vith 7.2.1.9 are permissible					
		device capable of keeping					
	•	hen a force of 5 lbf is					
	applied. There is	no impediment to the					
	closing of the door	rs. Hold open devices that					
	release when the	door is pushed or pulled are					
	permitted. Nonrate	ed protective plates of					
	unlimited height a	re permitted. Dutch doors					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155266		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 06/06/2024		
		ROVIDER OR SUPPLIER		1649 5	ADDRESS, CITY, STATE, ZIP COD SPY RUN AVENUE WAYNE, IN 46805	
	(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observation failed to ensure 1 of doors were provided keeping the door closing, latching an smoke. This deficit residents in the Beer Findings include:  Based on observation Director and Admir p.m., the corridor do Beecher dining room when tested. Based observation, the Macorridor door would when tested.  The finding was revenue.	Parts 403, 418, 460, 482,  S details of doors such as ngs, automatics closing  on and interview, the facility f 2 Beecher dining room double d with a means suitable for osed, had no impediment to d would resist the passage of ent practice could affect 20	K 0363	This plan of correction is prepand executed because the provisions of state and federa require it and not because Lift Care Center of Fort Wayne as with the allegations and citatic listed. Life Care Center of Fort Wayne maintains that the alledeficiencies do not jeopardize health and safety of the residenor is it of such character to lift our capabilities to render adecare. Please accept this plan correction as our credible allegation of compliance that alleged deficiencies have or we correct by the date indicated fremain in compliance with state and federal regulations, the fathas taken or will take the actic set forth in this plan of correct We respectfully request a descreview.  K363 Corridor Doors	al law e grees ons rt eged e the ents imit quate of the vill be to ate acility ons tion.

07/03/2024 PRINTED:

DEPARTMEN' CENTERS FOI	FORM APPROVED OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155266		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/06/2024
	PROVIDER OR SUPPLIED		1649 S	ADDRESS, CITY, STATE, ZIP COD SPY RUN AVENUE WAYNE, IN 46805	<u>,                                    </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	RESOLATORI OI			What Corrective Action will accomplished for those residents found to have been affected by this deficient practice:  The corridor double doors to to back of the Beecher dining rowas repaired so it would now into the frame.  How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken:  All residents and staff have the potential to be affected. Audit completed of all facility doors ensure they appropriately late into the frame.  What measures and what systemic changes will be made to ensure that the deficient practice doesn't recur:  Maintenance staff was education K363.  How the corrective action was be monitored to ensure the deficient practice will not reside, what quality assurance program will be put in place executive Director and/or designee will conduct audits of facility's doors 1x per week for months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results.	the oom latch  the he be ve one was to ch  ade ted will cur,  cur,  cor the or 6 ch

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system components will be reviewed by the QAPI Committee

on a monthly basis with

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		INSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTI	ON	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155266	B. WI	NG		06/06/	2024
NAME OF PROVIDER OR			STREET ADDRESS, CITY, STATE, ZIP COD 1649 SPY RUN AVENUE FORT WAYNE, IN 46805				
(X4) ID SU	MMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	T.C.	COMPLETION
TAG REGULA	ATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
complies Code, ele complies Code. Exi service pr 18.5.1.1, Based on of failed to en the space of in a safe of utilities to requires el with NFPA 2011 Editi boxes shal with the both use. Where the ground	Gas and Gas and t using owith NFF ctrical which NFF sting inspection of the sting inspection of the sting inspection of the sting of th	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life. 9.1.1, 9.1.2 on and interview the facility F1 electrical junction boxes in drop ceiling was maintained condition. LSC 19.5.1.1 requires with Section 9.1. LSC 9.1.2 riring and equipment to comply tional Electrical Code. NFPA 70, tle 314.28(3)(c) states junction tided with covers compatible titable for the conditions of tetal covers shall comply with rements of 250.110. This build affect 20 residents in one	K 05	511	subsequent plans of correction developed and implemented a deemed necessary. At that time analysis of data will be done to ensure the deficient practice of 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 Plant of Correction.  This plan of correction is preparand executed because the provisions of state and federal require it and not because Life Care Center of Fort Wayne agwith the allegations and citation listed. Life Care Center of Fort Wayne maintains that the allegation is it of such character to life our capabilities to render adequate. Please accept this plant correction as our credible allegation of compliance that it alleged deficiencies have or we correct by the date indicated to	ared law arees and the ents mit quate of the fill be	07/05/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLET	ED
		155266	B. W	ING		06/06/20	)24
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					PY RUN AVENUE		
LIFE CAF	RE CENTER OF FO	ORT WAYNE		FORT	WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUGERIC N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE .	DATE
		ons with the Maintenance			remain in compliance with sta	ie	
		our of the facility on 6/06/2024			and federal regulations, the fa		
	_	ectrical junction box in the			has taken or will take the action	· .	
	_	op ceiling in the corridor			set forth in this plan of correct		
	_	and 32 was not provided with a			We respectfully request a des		
		l exposed electrical wiring.			review.		
	Based on interview	-			100.000		
	observations, the Maintenance Director				K511 Utilities – Gas and Elec	tric	
	acknowledged the electrical junction box was not				What Corrective Action will		
		ver and had exposed wires.			accomplished for those		
					residents found to have been	n	
	This finding was re	eviewed with the Maintenance			affected by this deficient		
	Director and Administrator at the time of the exit				practice:		
	conference.				Upon identification a cover pla	ıte	
					was installed on the junction b		
	3.1-19(b)				in the space above the drop of		
					in the corridor between rooms	- 1	
					and 32.		
					How other residents having	the	
					potential to be affected by th		
					same deficient practice will l		
					identified and what corrective		
					action will be taken:		
					All residents and staff have the	e	
			potential to be affected. Audit was				
					completed of all facility junctio		
					boxes to ensure a cover plate		
					in place and no electrical wirin		
					exposed.	<u> </u>	
					What measures and what		
					systemic changes will be ma	ide	
					to ensure that the deficient		
					practice doesn't recur:		
					Maintenance staff was educat	ed	
					on K511.		
					How the corrective action wi	11	
					be monitored to ensure the		
					deficient practice will not red	cur,	
					i.e., what quality assurance	.,	
					program will be put in place:	;	
	1		1		-    -    -    -    -    -    -	1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155266		A. BUILDING 01  B. WING		COMPLETED 06/06/2024	
	ROVIDER OR SUPPLIER		1649 S	ADDRESS, CITY, STATE, ZIP COD PY RUN AVENUE WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0753 SS=D	NFPA 101 Combustible Deco	rations		Executive Director and/or designee will conduct audits of junction boxes 1x per week for months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results system components will be reviewed by the QAPI Commit on a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that tin analysis of data will be done to ensure the deficient practice of not reoccur and/or adapt audit schedules.  Compliance date: 7/5/2024, The Administrator at Life Care Certof Fort Wayne is responsible if ensuring compliance in this Plof Correction.	r 6 . s and ttee n as ne, o does t he nter
55=D Bldg. 01	Combustible Deco Combustible deco unless one of the f o Flame retardat fire-retardant coati for product. o Decorations m o Decorations e than 100 kilowatts 289. o Decorations, s paintings and othe walls, ceilings and accordance with 1	rations rations shall be prohibited			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155266	B. W	ING		06/06/	/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L			PY RUN AVENUE		
LIFE CAF	RE CENTER OF FO	ORT WAYNE			WAYNE, IN 46805		
	ı		1		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEI TOLENO I I		DATE
		l quantities that a hazard of					
	19.7.5.6	or spread is not present.					
	l e	on and interview, the facility	κn	753	This plan of correction is prepared	ared	07/05/2024
		f 61 resident room doors met	I K U	1133	and executed because the	uicu	07/03/2024
		LSC 19.7.5.6(4)(c) which			provisions of state and federal	law	
	prohibits combustible decorations from covering				require it and not because Life		
	more than 30 percent of a non-fire rated door. This				Care Center of Fort Wayne ag		
		ould affect two residents.			with the allegations and citation		
	•				listed. Life Care Center of For		
	Findings include:				Wayne maintains that the alleg		
					deficiencies do not jeopardize	-	
	Based on observations with the Maintenance				health and safety of the reside	ents	
		nistrator on 06/06/2024 at 11:27			nor is it of such character to lir	nit	
		sident room 42 was more than		our capabilities to render adequate			
	_	in combustible paper art.		care. Please accept this plan of			
		during observation. The			correction as our credible		
		ed the decorations covered			allegation of compliance that t		
		nt of the door and stated they			alleged deficiencies have or w		
	will discuss this wit	th the resident.			correct by the date indicated to		
	TE1 : C 1:	t that we take			remain in compliance with state		
		viewed with the Maintenance			and federal regulations, the fa		
	Director and Admir conference.	nistrator at the time of the exit			has taken or will take the action		
	conference.				set forth in this plan of correcti		
	3.1-19(b)				We respectfully request a desireview.	N.	
	3.1-17(0)				TEVIEW.		
					- K753 Combustible Decoration	ns	
					What Corrective Action will I		
					accomplished for those		
					residents found to have been	n	
					affected by this deficient		
					practice:		
					Upon identification, the		
					combustible decorative paper	art	
					was removed from resident ro	om	
					door for room #42.		
					How other residents having		
					potential to be affected by th		
					same deficient practice will l	be	

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Facility ID: 000167

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039	
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155266		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/06/2024	
	PROVIDER OR SUPPLIED			1649 S	ADDRESS, CITY, STATE, ZIP COD PY RUN AVENUE WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
					identified and what corrective action will be taken:  All residents and staff have the potential to be affected. Audit completed of the facility doorsensure the combustible decorations were 30% or less doors.  What measures and what systemic changes will be material 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 recise, what quality assurance program will be put in place. Executive Director and/or designee will conduct audits of facility doors 1x per week for months to ensure compliance. Any issues identified will be immediately addressed. The above stated audit results system components will be reviewed by the QAPI Commion a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that tin analysis of data will be done to ensure the deficient practice of not reoccur and/or adapt audit schedules.  Compliance date: 7/5/2024, T. Administrator at Life Care Ceremoners.	ee was sto sto sto sto sto sto sto sto sto st		

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Event ID:

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Facility ID: 000167

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of Fort Wayne is responsible in ensuring compliance in this Plan

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED	
		155266	B. WI	NG		06/06/	06/06/2024	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				PY RUN AVENUE			
LIFE CAF	RE CENTER OF FO	RT WAYNE			WAYNE, IN 46805			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	•	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE	DATE	
					of Correction.			
K 0761								
SS=F								
Bldg. 01								
	Based on observation	on, records review, and	K 0'	761	This plan of correction is prepa	ared	07/05/2024	
	interview, the facilit	y failed to ensure annual			and executed because the			
	-	ng of 5 of 5 fire door			provisions of state and federal	law		
		npleted in accordance of LSC			require it and not because Life			
		nicating openings in dividing			Care Center of Fort Wayne ag	rees		
	-	d by 19.1.1.4.1 shall be			with the allegations and citatio	ns		
		orridors and shall be protected			listed. Life Care Center of Fort			
		osing fire door assemblies.		Wayne maintains that the alleged		ged		
	,	3.) LSC 8.3.3.1 Openings			deficiencies do not jeopardize	the		
	_	re protection rating by Table			health and safety of the reside	nts		
	_	ected by approved, listed,			nor is it of such character to lir	nit		
		semblies and fire window			our capabilities to render adeq	uate		
		accompanying hardware,			care. Please accept this plan of	of		
		, closing devices, anchorage,			correction as our credible			
		nce with the requirements of			allegation of compliance that the			
		for Fire Doors and Other			alleged deficiencies have or w			
		s, except as otherwise			correct by the date indicated to			
	-	de. NFPA 80 5.2.1 states fire			remain in compliance with stat			
		ll be inspected and tested not			and federal regulations, the fa	-		
		and a written record of the			has taken or will take the actio			
	_	signed and kept for inspection			set forth in this plan of correcti			
		80, 5.2.4.1 states fire door			We respectfully request a desl	Κ		
		visually inspected from both			review.			
		verall condition of door			-			
		, 5.2.4.2 states as a minimum,			K761 Maintenance, Inspectio	<u>n</u>		
	the following items				& Testing - Doors			
		r breaks exist in surfaces of			What Corrective Action will be	e		
	either the door or fra				accomplished for those			
		ight frames, and glazing beads			residents found to have been	1		
		ely fastened in place, if so			affected by this deficient			
	equipped.				practice:			
		, hinges, hardware, and			Upon review of all facility			
		eshold are secured, aligned,			inspection reports, it was ident			
	_	er with no visible signs of			the annual fire door inspection			
	damage.		ı		were completed on 11/8/2023			

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9S4U21 Facility ID: 000167 If continuation sheet Page 24 of 34

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155266	B. WING		06/06/2024	
	ROVIDER OR SUPPLIER		1649 S	ADDRESS, CITY, STATE, ZIP COD PY RUN AVENUE WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDERIC DI AM OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	(4) No parts are mis (5) Door clearances listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open p (7) If a coordinator closes before the ac (8) Latching hardward door when it is in the coordinate or when it is in the coordinate	sing or broken. do not exceed clearances 3.1.7. device is operational; that is, pletely closes when operated position. is installed, the inactive leaf tive leaf. are operates and secures the ne closed position. are items that interfere or are not installed on the door or feations to the door assembly and that void the label. edge seals, where required, are their presence and integrity. ice could affect all residents.  At at 10:19 a.m., documentation are the tour between 11:30 a.m. are were five fire door assemblies and the tour between 11:30 a.m. are were five fire door assemblies and the tour between 11:30 a.m. are the fire door assemblies and the tour between 11:30 a.m. are the fire door assemblies and the tour between 11:30 a.m. are the fire door assemblies and the tour between 11:30 a.m. are the fire door assemblies and the tour between 11:30 a.m. are the fire door assemblies and the tour between 11:30 a.m. are the fire door assemblies and the fire door assemblies and the fire door and the fire doors and stated the are the fire door and stated the are operated the fire door and the fire doo		How other residents having potential to be affected by the same deficient practice will identified and what corrective action will be taken:  No staff or residents were affected doesn't recur: Maintenance staff was re-educated on fire door inspectas well as properly organizing keeping facility inspection reports/documentation.  How the corrective action will be monitored to ensure the deficient practice will inspection reports/documentation.  How the corrective action will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put in place. Executive Director and/or designee will conduct audits of facility's inspection reports 1x month for 6 months to ensure compliance and proper documentation is available. An issues identified will be immediately addressed. The above stated audit results system components will be reviewed by the QAPI Commit on a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that time the state of the staff is that time the deficient practice will not recise the system components will be reviewed by the QAPI Commit on a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that time	the ne be ve ected.  ade ection and ill cur, : of the per eny s and ttee en as ene,	
	and Maintenance D	irector at the exit conference.		analysis of data will be done to		
	2.1.10%			ensure the deficient practice d		
	3.1-19(b)			not reoccur and/or adapt audit	L	
			1	schedules	i	

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Compliance date: 7/5/2024, The

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155266	ľ	UILDING	onstruction 01	(X3) DATE COMPL 06/06/	ETED
	PROVIDER OR SUPPLIER			1649 SI	ADDRESS, CITY, STATE, ZIP COD PY RUN AVENUE WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					Administrator at Life Care Cer of Fort Wayne is responsible i ensuring compliance in this Pl of Correction.	n	
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and assoc of supplying servic 10-second criterio monthly test, a pro annually confirm t safety and critical and testing of the switches are perfo NFPA 110. Generator sets are exercised under to year in 20-40 day once every 36 mo Scheduled test un a complete simula automatic or manuloads, and are cor personnel. Mainte energy power sou accordance with N circuit breakers ar program for period components is est manufacturer requ of maintenance ar and readily availal and circuits are m and separate from Minimizing the pos	other alternate power lated equipment is capable be within 10 seconds. If the in is not met during the possess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the expected weekly, and 30 minutes 12 times a intervals, and exercised intervals, and exercised must be load conditions include					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 06/06/2024 155266 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1649 SPY RUN AVENUE LIFE CARE CENTER OF FORT WAYNE FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 K 0918 07/05/2024 This plan of correction is prepared interview, the facility failed to ensure an annual and executed because the fuel quality test was performed for 1 of 1 facility's provisions of state and federal law diesel-powered generator. NFPA 99, Health Care require it and not because Life Facilities Code, 2012 Edition Section 6.5.4.1.1.2 Care Center of Fort Wayne agrees states Type 2 EES (Essential Electrical System) with the allegations and citations generator sets shall be inspected and tested in listed. Life Care Center of Fort accordance with Section 6.4.4.1.1.3. Section Wayne maintains that the alleged 6.4.4.1.1.3 states maintenance shall be performed deficiencies do not jeopardize the in accordance with NFPA110, Standard for health and safety of the residents Emergency and Standby Power Systems, 2010 nor is it of such character to limit Edition, Chapter 8. NFPA 110, Section 8.3.8 states our capabilities to render adequate a fuel quality test shall be performed at least care. Please accept this plan of annually using tests approved by ASTM correction as our credible allegation of compliance that the standards. This deficient practice could affect all residents. alleged deficiencies have or will be correct by the date indicated to Findings include: remain in compliance with state and federal regulations, the facility Based on a records review with the Administrator has taken or will take the actions and the Maintenance Director on 06/06/24 at 10:00 set forth in this plan of correction. a.m., no documentation of an annual fuel quality We respectfully request a desk test for the diesel generator was available for review. review. Based on observation at 12:00 p.m., the facility had a diesel-powered generator in the **K918 Electrical Systems** parking lot. Based on interview at the time of **Essential Electric System** records review and observation, the Administrator Maintenance/Testing stated the facility did have a diesel fuel quality What Corrective Action will be test in June of 2023 but could not find the accomplished for those paperwork. residents found to have been affected by this deficient This finding was reviewed with the Administrator practice: and Maintenance Director at the exit conference. The Maintenance Director

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3.1-19(b)

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6/6/2024.

contacted vendor immediately

quality test completed on

upon identification with annual fuel

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155266		A. BUILDING B. WING	COMPLETED 06/06/2024	
	ROVIDER OR SUPPLIER RE CENTER OF FORT WAYNE	1649 S	ADDRESS, CITY, STATE, ZIP COD PY RUN AVENUE WAYNE, IN 46805	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PECULATORY OF LSC INENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	How other residents having a 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 aperformance of the annual fue quality test was added to the TELS Preventative Maintenance schedule. Any identified issues will be immediately addressed How the corrective action with be monitored to ensure the deficient practice will not recise, what quality assurance program will be put in place:  The above stated audit results system components will be reviewed by the QAPI Commit on a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that time analysis of data will be done to ensure the deficient practice of not reoccur and/or adapt audit schedules.  Compliance date: 7/5/2024. The Administrator at Life Care Centor of Fort Wayne is responsible in ensuring compliance in this Plant of Correction.	e de

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155266		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       06/06/2024			
	PROVIDER OR SUPPLIER		1649 S	ADDRESS, CITY, STATE, ZIP COD PY RUN AVENUE WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a p	ent - Power Cords and ent - Power Cords and patient care vicinity are only			
	used for compone patient-care-relate (PCREE) assemble assembled by quathe conditions of 1 the patient care vinon-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structure temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.30		K 0920	This plan of correction is prep	ared 07/05/2024
	in patient care locat rating of 1363A or of affects two resident Findings include:	1 flexible cords power strips ions met the required UL 50601-1. This deficient practice s.		and executed because the provisions of state and federa require it and not because Life Care Center of Fort Wayne ag with the allegations and citatic listed. Life Care Center of For Wayne maintains that the alle deficiencies do not jeopardize	I law e grees ons t ged
	p.m., a power-strip	in room 35 was in use within 6 re area that did not meet		health and safety of the reside nor is it of such character to li our capabilities to render adec	ents mit

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	l í	a. building <u>01</u>			COMPLETED	
		155266	B. W		<u> </u>			
				<del>-</del>				
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
					PY RUN AVENUE			
LIFE CAP	RE CENTER OF FO	DRT WAYNE		FORT WAYNE, IN 46805				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	1363A or 60601-1.	The power strip had a label			care. Please accept this plan	of		
	stating it "CONFOI	RMS TO UL STD 1363". Based			correction as our credible			
	on interview during	g observation. The			allegation of compliance that t	he		
	Administrator agree	ed the power strip did not meet			alleged deficiencies have or w	/ill be		
	UL 1363A or 6060	1-1.			correct by the date indicated t	0		
					remain in compliance with sta	te		
	The findings were r	reviewed with the Maintenance			and federal regulations, the fa	cility		
	Director and the Ad	lministrator during the exit			has taken or will take the action	ns		
	conference.				set forth in this plan of correct	ion.		
					We respectfully request a des	k		
	3.1-19(b)				review.			
					<u>-</u>			
					K920 Electrical Equipment –	-		
					Power cords and Extenstion	<u>s</u>		
					What Corrective Action will	be		
					accomplished for those			
					residents found to have been	n		
					affected by this deficient			
					practice:			
					Power strip was immediately			
					removed.			
					How other residents having			
					potential to be affected by th			
					same deficient practice will			
					identified and what corrective	'e		
					action will be taken:			
					All other residents and staff ha	ave		
					potential to be affected. Full			
					facility audit was completed to	t		
					ensure all in use power strips			
					meet regulation.			
					What measures and what			
					systemic changes will be ma	ide		
					to ensure that the deficient			
					practice doesn't recur:	,tod		
					Maintenance staff were educa	itea		
					on power strip use.	:11		
					How the corrective action w	II		
					be monitored to ensure the			
					deficient practice will not red	cur,		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		a. Building <u>01</u> B. Wing		COMPLETED 06/06/2024	
		155266	B. W	_		06/06/	2024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
LIFE CAF	RE CENTER OF FO	PRT WAYNE			PY RUN AVENUE VAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	i.e., what quality assurance		DATE
					program will be put in place: Executive Director and/or designee will conduct audits o rooms 1x per week for 6 mont to ensure compliance related t use of power strips. Any issue identified will be immediately addressed. The above stated audit results system components will be reviewed by the QAPI Commit on a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that tim analysis of data will be done to ensure the deficient practice d not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, TI Administrator at Life Care Cer of Fort Wayne is responsible in ensuring compliance in this PI of Correction.	f 5 hs to s and ttee n is ne, o oes tter n	
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in according another is in according of High Oxygen Used for I any gas from one prohibited in patie to liquid oxygen occurainers over 50 under 11.5.2.3.1 (	Transfilling Cylinders Transfilling Cylinders Gen from one cylinder to rdance with CGA P-2.5, In Pressure Gaseous Respiration. Transfilling of cylinder to another is Int care rooms. Transfilling containers or to portable In psi comply with conditions INFPA 99). Transfilling to ainers or to portable In posi comply with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155266	B. W	ING _		06/06/	/2024
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			PY RUN AVENUE		
LIEECAE		DT WAYNE			WAYNE, IN 46805		
LIFE CAP	RE CENTER OF FO	ORT WATNE		FORT	WATNE, IN 40803		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conditions under 1	11.5.2.3.2 (NFPA 99).					
	11.5.2.2 (NFPA 99	9)					
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms met		K 0	927	This plan of correction is prepa	ared	07/05/2024
					and executed because the		
	the requirement of I	NFPA 99, 2012 Edition Section			provisions of state and federal	law	
		Storage or Transfilling and			require it and not because Life	;	
		states mechanical exhaust to			Care Center of Fort Wayne ag	rees	
	_	pressure in the space shall be			with the allegations and citatio		
	_	sly, unless an alternative			listed. Life Care Center of Fort	į	
		by the authority having			Wayne maintains that the alle	ged	
	-	eficient practice could affect 30			deficiencies do not jeopardize	the	
	residents in one smo	oke compartment.			health and safety of the reside	nts	
					nor is it of such character to lir	nit	
	Findings include:				our capabilities to render adec	<sub>l</sub> uate	
					care. Please accept this plan of	of	
		ons with the Maintenance			correction as our credible		
		nistrator on 06/06/2024 at 11:38			allegation of compliance that t		
		n in the oxygen storage and			alleged deficiencies have or w		
		as not functioning and failed to			correct by the date indicated to		
		essure in the room. Based on			remain in compliance with stat		
		servation, the Maintenance			and federal regulations, the fa		
	Director agreed the	exhaust fan was not working.			has taken or will take the action		
					set forth in this plan of correcti		
		viewed with the Maintenance			We respectfully request a desi	K	
		nistrator at the time of the exit			review.	ļ	
	conference.				l <del>.</del>	ļ	
	2.1.10(1)				K927 Gas Equipment –	ļ	
	3.1-19(b)				Transfilling Cylinders		
					What Corrective Action will k	Эе	
					accomplished for those		
					residents found to have been	7	
					affected by this deficient		
					practice:		
					The exhaust fan in the oxygen	1	
					storage/transfilling room was		
					repaired.  How other residents having	tho	
					potential to be affected by the		
					same deficient practice will be		
					identified and what correctiv	E	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED		
		155266	B. WING 06/06/2024					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1649 SPY RUN AVENUE FORT WAYNE, IN 46805					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IIE	DATE	
	``				action will be taken: No other staff or residents weraffected. What measures and what systemic changes will be mato ensure that the deficient practice doesn't recur: Maintenance staff was educated on inspection of the facility exhaust fans, as well as monitoring frequency scheduled. TELS was increased for the exhaust fans to weekly. How the corrective action with be monitored to ensure the deficient practice will not receive, what quality assurance program will be put in place: Executive Director and/or designee will conduct audits of facility's exhaust fans 1x per with for 6 months to ensure compliant proper documentation is available. Any issues identified be immediately addressed. The above stated audit results system components will be reviewed by the QAPI Commit on a monthly basis with subsequent plans of correction developed and implemented a deemed necessary. At that time analysis of data will be done to ensure the deficient practice of not reoccur and/or adapt audit schedules. Compliance date: 7/5/2024, Tild Administrator at Life Care Cerof Fort Wayne is responsible in ensuring compliance in this Please and will be resuring compliance in this Please and will be resured to the provide the provided to the provided the provided to the provided the provided to the provided the provide	re  ade  ade  ade  ade  ade  ade  ade  a		
			1		I choding compliance in this Fi	uii		

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STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	A. BUILDING 01			COMPLETED	
		155266	B. WIN	B. WING		06/06/2024		
						<u> </u>		
NAME OF BROWDER OF CURRITIES				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER				1649 SI	PY RUN AVENUE			
LIFE CARE CENTER OF FORT WAYNE								
LIFE CA	ARE CENTER OF FC	ORT WAYNE	FORT WAYNE, IN 46805					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	_	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
·					of Correction.			

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