STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155694	A. BUILDING -- B. WING	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETZ NURSING HOME	116 BETZ RD AUBURN, IN 46706

(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: 07/29/24 Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860 At this Emergency Preparedness survey, Betz Nursing Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 114 and had a census of 72 at the time of this survey. Quality Review completed on 07/31/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/29/24 Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860 At this Life Safety Code survey, Betz Nursing Home was found not in compliance with Requirements for Participation in	K 0000	This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests paper compliance in lieu of a post survey review on or after August 16th, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Beard	HFA	08/12/2024

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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) 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 114 and had a census of 72 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/31/24			
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			

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	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 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 20 corridor doors on the memory care wing 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 up to 30 residents, as well as staff and visitors in the memory care wing. Findings include: Based on observation with the Executive Director and Maintenance Director on 07/29/24 at 11:58 a.m., during a tour of the facility, the corridor door to memory care facilitators office on the memory care wing was unable to latch into the frame. Based on observation the latch hole in the door frame had tape applied over the hole, preventing	K 0363	K363 Corridor-Doors What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Tape was immediately removed from memory care facilitators office and the door was able to latch. 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 residing on the memory care wing have the potential to be affected by the	08/16/2024

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	the door from properly latching. Based on interview with the Maintenance Director at the time of observation, he stated he did not know about the hole being taped. The Maintenance Director removed the tape at time of observation allowing the door to properly latch. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		same deficient practice. All staff to be in-serviced on not placing tape over door latches to prevent it from latching by 8/16/24. All doors have been inspected for tape over the latch to prevent it from latching and none has been found to be taped. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff to be in-serviced on not placing tape over door latches to prevent door from latching by 8/16/24. —— Maintenance Director/designee will check doors to ensure doors latch properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. Door latching CQI will be completed weekly X 4 weeks, and monthly X 3 months thereafter until compliance is achieved. If threshold of 100% is not met, an action plan will be developed to ensure compliance.	

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			By what date the systemic changes will be implemented; Date of completion is 8/16/24.	
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 a multiplug power strip in 1 of 68 resident rooms met UL 1363. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that	K 0920	K 920 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The multiplug power strip was immediately removed from the	08/16/2024

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	supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 1 resident who resides in resident room 706. Findings include: Based on observation with the Executive Director and Maintenance Director on 07/29/24 at 12:50 p.m., during a tour of the facility, resident room 706 was using a multiplug power strip for resident's personal electrical equipment including a refrigerator, television, and humidifier that lacked a UL 1363 label on the multiplug power strip. The Maintenance Director stated he regularly checks for these types of devices but was unaware that this one was in use. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		resident's room and provided with a medical grade power strip. 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 have the potential to be affected by the same deficient practice. All staff to be in-serviced by 8/16/24 on not using non-medical grade power strips. All rooms have been inspected for non-medical grade power strips and none are being used. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All staff to be in-serviced by 8/16/24 on not using non-medical grade power strips. Care Companions will complete daily rounds to identify and immediately correct any devices not plugged into the wall or a medical grade power strip. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Non-compliant multi-plug	

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			CQI will be completed weekly X 4 weeks, and monthly X 6 months thereafter until compliance is achieved. Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed to ensure compliance. By what date the systemic changes will be implemented; Date of completion is 8/16/24.	