STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155349	A. BUILDING -- B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE HOME	1900 RANDALLIA DR 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: 04/23/24 Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960 At this Emergency Preparedness survey, Saint Anne Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 166 certified beds. At the time of the survey, the census was 110. Quality Review completed on 04/24/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/23/24 Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960 At this LSC survey, Saint Anne Home was found not in compliance with Requirements for	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elaine Wilson	COO	06/12/2024

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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	155349	A. BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE HOME	1900 RANDALLIA DR FORT WAYNE, IN 46805

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	Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101, LSC and 410 IAC16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. The facility consists of two attached buildings: Bldg. #1 a three-story building Type II (222) and Bldg. #2 Type V (111). Building #1 is a three-story building with basement, is fully sprinklered, and is Type II (222) construction. 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. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility has a capacity of 166 and had a census of 110 at the time of this survey. Quality Review completed on 04/24/24			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and			

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	155349	A. BUILDING 01 B. WING	04/23/2024

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	* Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 4 hazardous storage room's corridor doors in the basement were not obstructed from closing. This deficient practice could affect staff in the basement. Findings include: Based on observation with the Facilities Director on 04/23/24 at 11:08 a.m., the housekeeping supply room in the basement contained over 20 boxes of combustible supplies and was greater than 50 square feet, making this a hazardous area. The set of double doors to the supply room were self-closing but the doors were held open with a locking device that did not release with the fire alarm. Based on an interview at the time of observation, the Maintenance Director agreed the supply room contained large amount of combustible storage, was larger than 50 square feet, and the corridor doors were held open by a device that did not release with the fire alarm. This finding was reviewed with the Facilities Director during the exit conference. 3.1-19(b)	K 0223	K-223 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No direct residents were effected. All residents had the potential to be effected. Corrective action to ensure safety of the residents is to complete routine audits of the doors found to be in non compliance to ensure all doors with self-closing features are not propped open, causing the doors to remain open in the event of a fire. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected. Corrective action to ensure safety of the residents is to complete routine audits of the doors found to be in non compliance to ensure all doors with self closing features are not propped open, causing the doors to remain open in the event of a fire. what measures will be put into place and what systemic changes will be made to ensure	05/10/2024

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	155349	A. BUILDING 01 B. WING	04/23/2024

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			that the deficient practice does not recur; The doors in the basement to the room greater than 50 square feet and with combustible storage will be audited weekly to ensure the door will not be propped open. Team members in-services on rationalization behind not propping doors open. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The door in question will be audited weekly to ensure that the door is not propped open. The team members will be educated on rationalization behind not propping doors open. The monthly QA committee will review the audits. Upon one year of compliant audits the audits will conclude. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of	

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			correction date. 5/21/24	
K 0225 SS=F Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 2 of 2 exit stairways had at least 50 percent of the exits lead directly to the outside. LSC 7.7.1 states exits shall terminate directly, at a public way or at an exterior exit discharge, unless otherwise provided in 7.7.1.2 through 7.7.1.4. LSC 7.7.2 Exits shall be permitted to discharge through interior building areas, provided that all of the following are met: (1) not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall discharge through areas on any level of discharge. This deficient practice could affect staff and all residents in Building One. Findings include: Based on observation with the Facilities Director on 04/23/24 between 11:00 a.m. and 1:30 p.m., the southwest stairs and northeast stairs, which total all stairway exits, discharged onto the first floor and not directly to the exterior of the building. Based on interview at the time of each observation, Facilities Director stated all stairwells discharged onto the first floor and not directly outside. This finding was reviewed with the Facilities Director during the exit conference.	K 0225	K-225 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The building does not have a stairwell directly to the outside of the building. Saint Anne's annually received a report from RTM consultants stating "…the facility will be considered to be in equivalent compliance with the provisions of NFPA 101-2012 upon completion of the plan for Improvement completed by the facility" how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents residing on 2nd and 3rd floor have the potential to be affected. The building does not have a stairwell directly to the outside of the building. Saint Anne's annually received a report	05/21/2024

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	3.1-19(b)		from RTM consultants stating "…the facility will be considered to be in equivalent compliance with the provisions of NFPA 101-2012 upon completion of the plan for Improvement completed by the facility" what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Saint Anne's will contract with RTM consultants in 2024 for a building review. The building review will take place on 5/21/24. A Consultant will come on site and evaluate the safety equivalency provided by Saint Anne Communities. It would be an unreasonable burden displacing residents with an astronomical financial burden to renovate the building to have a stairwell with a direct exit of the building. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Due to the nature of the citation, the ability to monitor the stairwells burdensome reconstruction is constant in nature.	

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			- by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 5/21/24	
K 0000 Bldg. 02	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/23/24 Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960 At this LSC survey, Saint Anne Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101, LSC and 410 IAC16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. The facility consists of two attached buildings:	K 0000		

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	155349	A. BUILDING 02 B. WING	04/23/2024

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	Bldg. #1 a three-story building Type II (222) and Bldg. #2 Type V (111). Building two is a one-story building consisting of the main entrance, dining, the chapel, and rehabilitation unit with a physical therapy gym is fully sprinklered of Type V (111) construction. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors and hard-wired smoke detectors in the Rehabilitation hall resident rooms. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility has a capacity of 166 and had a census of 110 at the time of this survey. Quality Review completed on 04/24/24			