PRINTED: 06/13/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155349	B. WING		04/23/2024	
			<u> </u>			
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
		-		ANDALLIA DR		
SAINT A	NNE HOME		FORT \	WAYNE, IN 46805		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg						
	An Emergency Pre	paredness Survey was	E 0000			
		ndiana Department of Health in				
	accordance with 42	-				
	Survey Date: 04/2	3/24				
	Survey Bute. 6 1/2	3,21				
	Facility Number: 0	000240				
	Provider Number:					
	AIM Number: 100					
	Allyl Nulliber, 100.	274900				
	At this Emanagement	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				
	I -	6 certified beds. At the time of				
	the survey, the cen	sus was 110.				
	Quality Review co	mpleted on 04/24/24				
K 0000						
IX 0000						
Bldg. 01						
Diag. 01	A Life Sofety Code	e (LSC) Recertification and State	V 0000			
		was conducted by the Indiana	K 0000			
		olth in accordance with 42 CFR				
	_	iiin in accordance with 42 CFR				
	483.90(a).					
	G D 04/0	2 /2 4				
	Survey Date: 04/2	3/24				
	E TV N 1 0	00240				
	Facility Number: 000240 Provider Number: 155349					
	AIM Number: 100	2/4960				
	1					
		y, Saint Anne Home was found				
	not in compliance	with Requirements for				
	1		1	<u> </u>		
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	
Flaine Wilson			COO		06/12/2024	

Any defiency statement 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 disclodays 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 155349			A. BUILDING B. WING	G 01	COMI	PLETED 3/2024	
	PROVIDER OR SUPPLIER	e e	STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 0223 SS=E Bldg. 01	Subpart 483.90(a), edition of National (NFPA) 101, LSC a was surveyed with a Care Occupancies. The facility consists Bldg. #1 a three-sto Bldg. #2 Type V (1) Building #1 is a threbasement, is fully seconstruction. The fawith smoke detection to the corridors and detectors in the residents have a sprinklered. All are were sprinklered. The and had a census of Quality Review corresponding with Self-Cle Doors with Self-Cle Doors with Self-Cle Doors in an exit penclosure, or horizor hazardous area and kept in the cle open by a release 7.2.1.8.2 that autodoors throughout entire facility upon Required manual tocal smoke detection which is the cleoned of the cleone	ee-story building with prinklered, and is Type II (222) acility has a fire alarm system on in the corridors, areas open battery-operated smoke dent rooms. All areas where ustomary access were as providing facility services the facility has a capacity of 166 of 110 at the time of this survey. Inpleted on 04/24/24 Iosing Devices losing Devices assageway, stairway zontal exit, smoke barrier, a enclosure are self-closing based position, unless held advice complying with omatically closes all such the smoke compartment or a activation of: all fire alarm system; and sectors designed to detect rough the opening or a setection system; and					
	Automatic spilling	der system, if installed; and	1	ĺ		1	

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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 01 B. WING 04/23/2024 155349 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1900 RANDALLIA DR SAINT ANNE HOME FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE * 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 K 0223 K-223 05/10/2024 failed to ensure 1 of 4 hazardous storage room's corridor doors in the basement were not what corrective action(s) will obstructed from closing. This deficient practice be accomplished for those could affect staff in the basement. residents found to have been affected by the deficient practice Findings include: No direct residents were effected. All residents had the Based on observation with the Facilities Director potential to be effected. Corrective on 04/23/24 at 11:08 a.m., the housekeeping action to ensure safety of the supply room in the basement contained over 20 residents is to complete routine boxes of combustible supplies and was greater audits of the doors found to be in than 50 square feet, making this a hazardous area. non compliance to ensure all The set of double doors to the supply room were doors with self-closing features are self-closing but the doors were held open with a not propped open, causing the locking device that did not release with the fire doors to remain open in the event alarm. Based on an interview at the time of of a fire. observation, the Maintenance Director agreed the supply room contained large amount of how other residents having combustible storage, was larger than 50 square the potential to be affected by the feet, and the corridor doors were held open by a same deficient practice will be device that did not release with the fire alarm. identified and what corrective action(s) will be taken; This finding was reviewed with the Facilities Director during the exit conference. All residents have the potential to be affected. Corrective 3.1-19(b) 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

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changes will be made to ensure

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155349	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/23/2024	
	ROVIDER OR SUPPLIE	R	1900 R	ADDRESS, CITY, STATE, ZIP COD RANDALLIA DR WAYNE, IN 46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY 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	
				that the deficient practice doe recur;		
				The doors in the basement to the room greater than 50 so feet and with combustible stor will be audited weekly to ensure the door will not be propped on Team members in-services or rationalization behind not proposed of the doors open.	quare rage Ire pen.	
				how the corrective action will be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place.	e r,	
				The door in question will audited weekly to ensure that door is not propped open. The team members will be educate on rationalization behind not propping doors open. The mo QA committee will review the audits. Upon one year of compliant audits the audits wi conclude.	the eed nthly	
				by what date the system changes for each deficiency was be completed. After submittin acceptable Plan of Correction is determined that the correction will not be completed by the dipreviously submitted, the Divisioneeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the undated of	vill g an , if it on ate sion n as d to	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155349	r í	ILDING NG	CONSTRUCTION (X3) DATE SURV O1 COMPLETE 04/23/202		LETED	
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME				1900 R	ADDRESS, CITY, STATE, ZIP COD ANDALLIA DR WAYNE, IN 46805			
(X4) ID PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION	
K 0225 SS=F Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures 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		K 02	TAG	CROSS-REFERENCED TO THE APPROPRIA) will ice; ave a e of hually ility e upon he	05/21/2024	
	outside.	viewed with the Facilities			All residents residing on and 3rd floor have the potenti be affected. The building does have a stairwell directly to the outside of the building. Saint Anne's annually received a re	al to s not		

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155349	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/23/2024			
	PROVIDER OR SUPPLIEF		1900 F	STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRI DEFICIENCY)	5.112			
	3.1-19(b)			from RTM consultants stating "the facility will be consider be in equivalent compliance we the provisions of NFPA 101-2 upon completion of the plan for Improvement completed by the facility"	ed to vith 012 or			
				what measures will be printo place and what systemic changes will be made to ensuthat the deficient practice doerecur; Saint Anne's will contrar with RTM consultants in 2024 building review. The building will take place on 5/21/24. A Consultant will come on site a evaluate the safety equivalen 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 will direct exit of the building.	re s not ct for a review and cy ng al			
				how the corrective actio will be monitored to ensure th deficient practice will not recu i.e., what quality assurance program will be put into place Due to the nature of the citation, the ability to monitor stairwells burdensome reconstruction is constant in nature	e r,			

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155349	A. BUILDING B. WING	01	COMPLETED 04/23/2024	
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME		STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR 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	
K 0000 Bldg. 02	Licensure Survey w Department of Healt 483.90(a). Survey Date: 04/23 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this LSC survey, not in compliance w Participation in Mec Subpart 483.90(a), I edition of National I (NFPA) 101, LSC a was surveyed with C Care Occupancies.	00240 55349	K 0000	by what date the system changes for each deficiency who completed. After submitting acceptable Plan of Correction is determined that the correction will not be completed by the dispreviously submitted, the Divisioneds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plat correction date. 5/21/24	vill g an , if it on ate sion n as d to	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155349	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/23/2024		
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME				STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG	*	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
	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							

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