		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER		A. BUILDING		COMPLETED	
155364		B. WING 06/04/2025			2025		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
BYRON HEALTH CENTER					EACON STREET VAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		T	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)	TE	DATE
E 0000							
Bldg	4 E B	1 0	E 0/				
		paredness Survey was diana Department of Health in	E 00	000			
	accordance with 42	-					
	accordance with 42	CI K 403.73.					
	Survey Date: 06/04/	/25					
	EUG-N 1 A	00255					
	Facility Number: 00 Provider Number: 1						
	AIM Number: 1002						
	Tilly Tullioet. 1002	273200					
	At this Emergency Preparedness Survey, Byron						
	Health Center 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 120 and had a census of 100 at the						
	time of this survey.						
	Quality Review con	npleted on 06/09/25					
K 0000							
Bldg. 02	ATICOC: OI	1 - 11 - 1			T . D		
	_	survey was conducted by the of Health in accordance with	K 00)00	This Plan of Correction is Byro		
	42 CFR 483.90(a).	of freaturin accordance with	1		Health Center's credible allegated of compliance. It is the intention		
	72 CI K 703.70(a).				of Byron Health Center to be in		
	Survey Date: 06/04/	/25			complete compliance with all	•	
	Sai. 103 Date: 00/0 1/25				Federal and State guidelines.		
	Facility Number: 0	00255			Preparation and/or execution	of	
	Provider Number:		1		this plan of correction does no		
	AIM Number: 1002	273280			constitute admission or agreer		
	Audi Tie e e				by the provider of the truth of t		
		Code Survey, Byron Health	1		facts alleged or conclusions se		
	Requirements for Pa	ot in compliance with			forth in the state deficiencies.	ıne	
	-	, 42 CFR Subpart 483.90(a),			plan of correction is prepared and/or executed because the		
	iviculcate/iviculcatu,	, 12 of K buopun 403.70(a),			and/or executed pecause the		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Sarah Starcher Executive Director/COO 06/19/2025

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 02 B. WING 06/04/2025 155364 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1661 BEACON STREET BYRON HEALTH CENTER 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Life Safety from Fire and the 2012 edition of the provisions of federal and state law National Fire Protection Association (NFPA) 101, require it. Life Safety Code (LSC), Chapter 18, New Health We are requesting a desk Care Occupancies and 410 IAC 16.2. review/paper compliance. This one-story facility was determined to be of K 511 NFPA 101 Life Safety Type V (111) construction and was fully **Code Standards** sprinklered. The facility has a fire alarm system What corrective action(s) will with smoke detection in corridors, areas open to be accomplished for those the corridors, and in resident sleeping rooms. The residents found to have been facility consists of five (5) one-story affected by the deficient comprehensive care wings and one (1) two-story practice? residential care wing separated by a two-hour fire The electrical receptacles to the barrier, all connecting to a common services core. right of the sinks in all five The building is partially protected by a type II ESS med-rooms were switched to GFCI 300 kW diesel powered generator. The facility has protected receptacles. a capacity of 120 and had a census of 100 at the How other residents having the time of this survey. potential to be affect by the same deficient practice will be All areas where the residents have customary identified and what corrective access were sprinklered. The facility had a action(s) will be taken? detached maintenance building that was not All residents had the potential to sprinklered. be affected by this practice. The electrical receptacles to the right Quality Review completed on 06/09/25 of the sinks in all five med-rooms were switched to GFCI protected receptacles. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All receptacles are affixed to the wall so no other measure or systemic change needs to be in place. (K 511 Attachment 1) How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance

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

PRINTED: 06/20/2025 FORM APPROVED OMB NO. 0938-039

i '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 06/04/2025	
	ROVIDER OR SUPPLIER		1661 B	ADDRESS, CITY, STATE, ZIP COD SEACON STREET 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
				program will be put into place All receptacles are affixed so no other measure or systemic change needs to be in place. By what date the systemic changes will be completed? July 4, 2025		
				K 921 NFPA 101 Life Safety Code Standards What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? PCREE inspections to be conducted on all resident care related electrical equipment. (K 921 Attachment 2) How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken? All residents had the potential to be affected. PCREE inspection to be conducted on all resident care related electrical equipment (K 921 Attachment 2) What measures will be put interplace or what systemic changes will be made to ensure that the deficient	ne o s nt.	

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Event ID:

KX8321

Facility ID: 000255

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practice does not recur?
PCREE inspections to be

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	T OF HEALTH AND HU					TED: 06 M APPRO B NO. 0938	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION 02	(X3) DATE S		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364		A. BUILDING B. WING	COMPLETED 06/04/2025			
	PROVIDER OR SUPPLIEI	र	1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET WAYNE, IN 46805			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5	*
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLE	
				completed annually, when new equipment is put into use and when repaired or modified. How the corrective action(s) will be monitored to ensure the deficient practice will not reduce, what quality assurance program will be put into place. The Director of Plant Operation or their designee, will review 2 of PCREE inspection documentation monthly. The inspection reports will be discussed in the monthly QAF	the cur ce? ons,		

K 0511
K 0511 SS=E Bldg. 02
Bldg. 02

NFPA 101

Utilities - Gas and Electric

Based on observation and interview, the facility failed to ensure 5 of 10 med-room receptacles within 6 feet from a sink or located in a wet location were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles

K 0511

K 511 NFPA 101 Life Safety **Code Standards**

By what date the systemic changes will be completed?

meetings.

July 4, 2025

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The electrical receptacles to the

right of the sinks in all five med-rooms were switched to GFCI protected receptacles. How other residents having the

potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken? All residents had the potential to

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06/19/2025

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
155364		B. WING 06/04/2025					
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1661 BEACON STREET FORT WAYNE, IN 46805				
BINOMILALITIOLINEN					T +0005		
(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)		PLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			ATE
	through (8) shall ha	tions specified in 210.8(B)(1)			be affected by this practice. The		
		rotection for personnel.			electrical receptacles to the rig of the sinks in all five med-roo	•	
		Kitchens, (3) Rooftops, (4)			were switched to GFCI protec		
	Outdoors,	ixionens, (3) ixoonops, (1)			receptacles.		
	· · · · · · · · · · · · · · · · · · ·	eceptacles are installed within			What measures will be put in	to	
		outside edge of the sink.			place or what systemic		
		tions, (7) Locker rooms with			changes will be made to		
		ng facilities, (8) Garages,			ensure that the deficient		
	service bays, and si	milar areas where electrical			practice does not recur?		
		nt, electrical hand tools.			All receptacles are affixed to t	ne	
		Vet Locations, requires all			wall so no other measure or		
	_	ed equipment within the area of			systemic change needs to be	in	
		have GFCI protection. Note:			place. (K 511 Attachment 1)		
	Moisture can reduce the contact resistance of the				How the corrective action(s)		
		insulation is more subject to			will be monitored to ensure t		
		ent practice could affect 5			deficient practice will not rec	ur	
	residents in the therapy gym. This deficient				i.e., what quality assurance		
	_	et 25 residents in the dining program will be put into place?					
	room.				All receptacles are affixed so	10	
	Findings include:				other measure or systemic change needs to be in place. By what date the systemic		
	Based on observation	ons with the Maintenance			changes will be completed?		
	Director and Assista	ant Administrator on 06/04/25			July 4, 2025		
	between 11:00 a.m.	and 1:45 p.m., in all five					
		eptacles to the right of each					
		et from the water source and					
	_	ected. Based on an interview at					
		p.m., the Maintenance Director					
		tric receptacles to the right of					
		med-rooms were not GFCI					
	protected and were	within 3 feet of a water source.					
	This was various d	with the Administrator, the					
		rator, and Maintenance					
		exit conference at 2:00 p.m.					
	Director during the	exit conference at 2.00 p.m.					
	3.1-19(b)						

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155364		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/04/2025		
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER		1661 E	ADDRESS, CITY, STATE, ZIP COD BEACON STREET WAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0921	NFPA 101				
SS=F	Electrical Equipme	ent - Testing and			
Bldg. 02	Maintenanc				
	Based on records re	view, observation, and	K 0921	K 921 NFPA 101 Life Safety	06/19/2025
	interview, the facilit	ty failed to maintain 1 of 1		Code Standards	
	complete document	ation of inspections for		What corrective action(s) wil	II
	Patient-Care Related	d Electrical Equipment		be accomplished for those	
	(PCREE). NFPA 9	9 2012 edition, sections 10.3 and		residents found to have been	n
	10.5 states the physi	ical integrity, resistance,		affected by the deficient	
	leakage current, and	touch current tests for fixed		practice?	
	and portable PCREI	E is performed as required in		PCREE inspections to be	
	10.3. Testing interv	als are established with		conducted on all resident care	;
	policies and protoco	ols. All PCREE used in patient		related electrical equipment. (к
	care rooms is tested	in accordance with 10.3.5.4 or		921 Attachment 2)	
	10.3.6 before being	put into service and after any		How other residents having	the
	_	on. Any system consisting of		potential to be affect by the	
	-	pliances demonstrates		same deficient practice will be	pe
	-	FPA 99 as a complete system.		identified and what corrective	
	-	structions, and procedures		action(s) will be taken?	
		nufacturer include information		All residents had the potential	to
		3.1.1 and are considered in the		be affected. PCREE inspectio	
		rogram for electrical equipment		to be conducted on all resider	
		rical equipment instructions		care related electrical equipme	
		anuals are readily available,		(K 921 Attachment 2)	
	and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and			What measures will be put in	nto
				place or what systemic	
				changes will be made to	
		intained for a period of time to		ensure that the deficient	
		ance in accordance with the		practice does not recur?	
	_	sonnel responsible for the		PCREE inspections to be	
		e and use of electrical		completed annually, when nev	w I
	· ·	continuous training. This		equipment is put into use and	
	deficient practice af	_		when repaired or modified.	
				How the corrective action(s)	
	Findings include:			will be monitored to ensure to	
				deficient practice will not rec	
	Based on records re	view with the Maintenance		i.e., what quality assurance	
		sistant Administrator on		program will be put into place	ce?
		.m., there was no documentation		The Director of Plant Operation	
		to show testing of PCREE		or their designee, will review 2	
1	i	~	1	· · · · · · · · · · · · · · · · · · ·	1

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Facility ID: 000255

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

PRINTED: 06/20/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155364	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2025	
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER		1661 B	ADDRESS, CITY, STATE, ZIP COD EACON STREET NAYNE, 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
	used in the facility. Based on observation from 11:20 a.m. to 1:30 p.m., each resident room contained PCREE such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interviews at 11:20 a.m. and 1:30 p.m. the Maintenance Director stated PCREE in the facility was not inspected for physical integrity, resistance, leakage current, and touch current. This was reviewed with the Administrator, the Assistant Administrator, and Maintenance Director during the exit conference at 2:00 p.m.			of PCREE inspection documentation monthly. The inspection reports will be discussed in the monthly QAP meetings. By what date the systemic changes will be completed? July 4, 2025	I	
	3.1-19(b)					

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