PRINTED: 08/10/2023

EPARTMENT OF HEALTH AND HUN	FORM APPROVED			
ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
	155798	B. WING		07/19/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4111 PARK PLACE DRIVE	

ASHTO	N CREEK HEALTH AND REHABILITATION CENTER		PARK PLACE DRIVE WAYNE, IN 46845	
(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.	E 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or	
	Survey Date: 07/19/23 Facility Number: 012861 Provider Number: 155798 AIM Number: 201080610 At this Emergency Preparedness survey, Ashton Creek Health and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 139 and had a census of 111 at the time of this survey.		execution of this plan of correction does not constitue admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of the federal and state law. We respectfully request paper complaince for this plan of correction.	
E 0004 SS=F Bldg	Quality Review completed on 07/24/23 403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility]			

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

TITLE (X6) DATE

Molly Linder Administrator 08/07/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: LD6U21 Facility ID: 012861 If continuation sheet Page 1 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155798	· /	JILDING	INSTRUCTION	COMPL 07/19/	ETED
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		4111 PA	ADDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE WAYNE, IN 46845		
(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)	ΤE	(X5) COMPLETION DATE
	comprehensive en program that meet section. The emer program must include the following elem (a) Emergency Pladevelop and maint preparedness plar and updated at least statement of the following elem (a) Emergency Pladevelop and maint preparedness plar and updated at least statement of the following element of the follow	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital apply with all applicable in docal emergency cuirements. The [hospital or in plan in a mergency preparedness is the requirements of this in all-hazards approach. Bes at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. Ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated], ast every 2 years.					
	failed to review and Preparedness Plan (iew and interview, the facility update the Emergency EPP) at least annually in CFR 483.73(a). This deficient	E 00	004	Corrective action for affected residents: 1. A meeting was held with		08/04/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21 Facility ID: 012861

If continuation sheet Page 2 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155798		ľ í	JILDING	INSTRUCTION	COMPL 07/19/	ETED	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		4111 P	ADDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE WAYNE, IN 46845		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
		view with the Administrator			management team to discuss review the EPP and any needs updates. How other residents have potential to the potential team to discuss review to discuss review the EPP and any needs to discuss review the EPP and any needs to discuss review the EPP and any needs to discuss review the EPP and any needs to discuss review the EPP and any nee	ed	
	a.m., no documenta the EPP was review year. Based on an in review, the Mainter	tion could be found to show red and updated within the last atterview during records nance Director stated the EEP red or updated within the last			to be affected: 2. All residents have the poter to be affected by the alleged deficient practice. Measures put into place and automatic charges:	ntial	
		viewed with the Administrator irector during the exit			systematic changes: 3. The management staff revifor the EPP will be scheduled. March of every year moving forward.	for	
					How the corrective action will I monitored: 4. Results of the March review the EPP will be forwarded to the Quality Assurance Committee review.	v of ne	
					Date Systemic changes will be completed:		
					Systemic changes for deficien will be completed by 8/4/23	су	
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b),					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

If continuation sheet

Page 3 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155798	ľ í	UILDING	NSTRUCTION	COMPL 07/19/	ETED
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		4111 PA	DDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE VAYNE, IN 46845		
(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
	REGULATORY OR §441.184(b), §460 §483.73(b), §483. §485.68(b), §485. §485.920(b), §486. §494.62(b). (b) Policies and properties on the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and use	2. LSC IDENTIFYING INFORMATION 2.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b), 2. Cocedures. [Facilities] must ement emergency cies and procedures, based eplan set forth in paragraph risk assessment at 10 of this section, and the 10 an at paragraph (c) of this 10 sies and procedures must 10 paragraph (c) of this 11 sies and procedures must 12 paragraph (d) Policies 3. At §483.73(b):] Policies 3. The LTC facility must ement emergency cies and procedures, based eplan set forth in paragraph risk assessment at				TE	
	communication pla	of this section, and the an at paragraph (c) of this sies and procedures must updated at least annually.					
	*Additional Requir ESRD Facilities:	rements for PACE and					
	procedures. The develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) communication pla	PACE organization must ement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21 Facility ID: 012861

If continuation sheet Page 4 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155798	A. BU	2) MULTIPLE CONSTRUCTION A. BUILDING 3. WING			(X3) DATE SURVEY COMPLETED 07/19/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 4111 PARK PLACE DRIVE FORT WAYNE, IN 46845				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE	
IAU	address managen nonmedical emerginited to: Fire; eq failure; care-relate disasters likely to safety of the partic. The policies and previewed and upd. *[For ESRD Facilitiand procedures. develop and imple preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication plasection. The policibe reviewed and uyears. These emenot limited to, fire, failures, care-relat supply interruption likely to occur in tha rea. Based on record rev	ment of medical and gencies, including, but not uipment, power, or water and emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be ated at least every 2 years. Ities at §494.62(b):] Policies The dialysis facility must ement emergency cies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 ergencies include, but are equipment or power and natural disasters are facility's geographic view and interview, the facility	E 00		Corrective action for affected		08/04/2023	
	Preparedness Plan (were reviewed and	I update the Emergency (EPP) Policies and Procedures (updated at least annually in (CFR 483.73(a). This deficient (at all occupants.			residents: 1. A meeting was held with management team to discuss review the EPP and any need updates.			
	and Maintenance D a.m., no documenta the EPP Policies and and updated within	eview with the Administrator irector on 07/19/23 at 10:41 tion could be found to show d Procedures were reviewed the last year. Based on an cords review, the Maintenance			How other residents have pote to be affected: 2. All residents have the pote to be affected by the alleged deficient practice.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

If continuation sheet

Page 5 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155798		UILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/19/2023
	PROVIDER OR SUPPLIEI	RAND REHABILITATION CENTER	₹	4111 P	ADDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE WAYNE, IN 46845	
(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
		EEP Policies and Procedures wed or updated within the last			Measures put into place and systematic changes:	
This finding was reviewed with the Administrator and Maintenance Director during the exit conference.				The management staff rev for the EPP will be scheduled March of every year moving forward.		
					How the corrective action will monitored:	be
					Results of the March reviethe EPP will be forwarded to to Quality Assurance Committee review.	he
					Date Systemic changes will be completed:	е
					Systemic changes for deficier will be completed by 8/4/23	ncy
E 0029 SS=F Bldg	484.102(c), 485.6 485.727(c), 485.9 491.12(c), 494.62 Development of C §403.748(c), §416 §441.184(c), §466 §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 483.73(c), 25(c), 485.68(c), 20(c), 486.360(c),				
	an emergency pre plan that complies local laws and mu	ust develop and maintain eparedness communication s with Federal, State and ust be reviewed and updated ears [annually for LTC				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21 Facility ID: 012861

If continuation sheet Page 6 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155798		JILDING	ONSTRUCTION	(X3) DATE COMPL 07/19 /	ETED
	PROVIDER OR SUPPLIEI	R AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 4111 PARK PLACE DRIVE R FORT WAYNE, IN 46845				
(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)	ΓΕ	(X5) COMPLETION DATE
	failed to review and Preparedness Plan (was reviewed and u accordance with 42 practice could affect Findings include: Based on records reand Maintenance Da.m., no documentathe EPP Communicand updated within interview during re Director stated the has not been review year. This finding was reand Maintenance Dard Conference.	eview with the Administrator prector on 07/19/23 at 10:41 ation could be found to show cation program was reviewed the last year. Based on an cords review, the Maintenance EEP Communication program and or updated within the last viewed with the Administrator prector during the exit	E 00	029	Corrective action for affected residents: 1. A meeting was held with management team to discuss review the EPP and any needs updates. How other residents have pote to be affected: 2. All residents have the poter to be affected by the alleged deficient practice. Measures put into place and systematic changes: 3. The management staff revisor the EPP will be scheduled March of every year moving forward. How the corrective action will be monitored: 4. Results of the March review the EPP will be forwarded to the Quality Assurance Committee review. Date Systemic changes will be completed: Systemic changes for deficient will be completed by 8/4/23	ed ential ential ew for oe for	08/04/2023
E 0036 SS=F	403.748(d), 416.5 441.184(d), 482.1	4(d), 418.113(d), 5(d), 483.475(d), 483.73(d),					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

If continuation sheet

Page 7 of 18

PRINTED: 08/10/2023 RM APPROVED MB NO. 0938-039

EPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDIC	CAID SERVICES		OM			
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPI			

AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER ASHTON CREEK HEALTH AND REHABILITATION CENTER		4111 P	ADDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE WAYNE, IN 46845	COM	X3) DATE SURVEY COMPLETED 07/19/2023	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
Bldg	484.102(d), 485.6 485.727(d), 485.6 485.727(d), 494.62 EP Training and \$403.748(d), \$41 \$441.184(d), \$46 \$483.73(d), \$483 \$485.68(d), \$485 \$485.920(d), \$48 \$494.62(d). *[For RNCHIs at \$400.84 Hospice at \$418.1 PACE at \$460.84 HHAs at \$484.10 CAHs at \$486.62 485.727, CMHCs \$486.360, and RH Training and testif develop and main preparedness training and testif develop and main preparedness training and testif in paragraph (a) consistency plots as the section plan at paragraph training and testif reviewed and upon the section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section plan at paragraph (b) of this section, ris (a)(1) of this section this context that the section this context	625(d), 485.68(d), 920(d), 486.360(d), 92(d)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

If continuation sheet

Page 8 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155798		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/19/2023		
	OVIDER OR SUPPLIER	AND REHABILITATION CENTER		4111 PA	DDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE VAYNE, IN 46845		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Έ	(X5) COMPLETION DATE	
	must be reviewed annually.	and updated at least					
	testing. The ICF/II maintain an emergand testing prograe emergency plan sethis section, risk a (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed 2 years. The ICF/II requirements for eat §483.470(i). *[For ESRD Facility Training, testing, and the semination of the emergency preparand patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at para and the communic of this section. The orientation program updated at every 2 and testing procedures at persuppose the procedure of the section.	ties at §494.62(d):] and orientation. The ast develop and maintain an redness training, testing ation program that is based replan set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) he training, testing and m must be evaluated and					
	Based on record rev failed to review and Preparedness Plan (program was review annually in accordance)	view and interview, the facility I update the Emergency (EPP) Training and Testing ved and updated at least nce with 42 CFR 483.73(a). ice could affect all occupants.	E 00	36	Corrective action for affected residents: 1. A meeting was held with management team to discuss review the EPP and any neede updates.		08/04/2023
	Findings include:				How other residents have pote	ential	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

If continuation sheet Page 9 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155798	B. WING		07/19/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	4111	ET ADDRESS, CITY, STATE, ZIP COD 1 PARK PLACE DRIVE RT WAYNE, IN 46845		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) to be affected: 2. All residents have the pote to be affected by the alleged deficient practice.	DATE	
	Maintenance Direct Testing program ha updated within the l This finding was re-	or stated the EEP Training and s not been reviewed or		Measures put into place and systematic changes: 3. The management staff rev for the EPP will be scheduled March of every year moving forward. How the corrective action will monitored: 4. Results of the March reviet the EPP will be forwarded to a Quality Assurance Committee review. Date Systemic changes will be completed: Systemic changes for deficier will be completed by 8/4/23	for be w of the e for	
K 0000						
Bldg. 01	Licensure Survey w	2861	K 0000	This plan of correction is the center's credible allegation of compliance. Preparation and execution of this plan of corredoes not constitue admission agreement by the provider of truth of the facts alleged or conclusions set forth in the statement of deficiencies. Th	/or ction or the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

If continuation sheet Page 10 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155798			JILDING	onstruction 01	(X3) DATE COMPL 07/19 /	ETED			
NAME OF PROVIDER OR SUPPLIER ASHTON CREEK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 4111 PARK PLACE DRIVE FORT WAYNE, IN 46845					
ASHTON	I CREEK HEALTH /	AND REHABILITATION CENTER		FORT	VATNE, IN 40045				
(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 DEFICIENCY)	TE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE		
	Health and Rehabilicompliance with Remain Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (Life Safety Code (Life Safety Code) This one story facilication Type V (111) constitution on the corridors and the resident rooms. 139 and had a censular survey. All areas where the access were sprinkle facility services were	Code survey, Ashton Creek itation Center was found not in equirements for Participation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, areas open hard wired smoke detectors in The facility has a capacity of as of 111 at the time of this residents have customary ered. All areas providing			plan of correction is prepared and/or executed soley becaus is required by the provisions of federal and state law. We respectfully request paper complaince for this plan of correction.				
K 0223 SS=E Bldg. 01	enclosure, or horizor hazardous area and kept in the cloopen by a release 7.2.1.8.2 that autodoors throughout entire facility upon * Required manua * Local smoke det	losing Devices assageway, stairway zontal exit, smoke barrier, a enclosure are self-closing bed position, unless held device complying with bematically closes all such the smoke compartment or							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21 Facility ID: 012861

If continuation sheet Page 11 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155798		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 07/19/2023			
	PROVIDER OR SUPPLIER		4111	FADDRESS, CITY, STATE, ZIP COD PARK PLACE DRIVE FWAYNE, IN 46845	
ASHTON (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION required smoke detection system; and * Automatic sprinkler system, if installed; and * 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 2 laundry doors to a 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. This deficient practice could affect staff in the service hall. Findings include: Based on observation during a tour of the facility with Maintenance Director on 07/19/23 at 9:30 a.m., the laundry room contained fuel fired		FORT ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY) Corrective action for affected residents: 1. Items propping the laundry door were removed and door immediately closed. How other residents have the potential to be affected: 2. This deficient practice coulaffect in the service hall. Measure put into place and	08/04/2023
	propped open from at the time of observ Director agreed the device that did not r	self-closing, but the door was the front. Based on interview vation, the Maintenance door was held open with a elease with the fire alarm. iewed with the Maintenance ministrator during the exit		systematic changes: 3. An audit will be completed daily for 6 weeks, 3 times a w for 3 weeks and weekly until a compliant. How the corrective action will monitored: 4. Results of this audit will be forwarded to the Quality Committee for review monthly months with a goal of 100% compliance. Once 100% compliance is achieved frequent of further review will be determined by the QAPI committee. Date systemic Changes will be completed:	be for 6 ency mined

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

If continuation sheet Page 12 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155798	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/19/2023
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	4111 P	ADDRESS, CITY, STATE, ZIP COD PARK PLACE DRIVE WAYNE, IN 46845	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
				Systemic changes for deficien will be complete by 8/4/23	су
K 0324 SS=E Bldg. 01	Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord. 19.3.2.5.2 * cooking facilities smoke compartmentients comply with 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer productions under a Cooking facilities NFPA 96 per 9.2.2 enclosed as hazabe open to the cooking facilities NFPA 96 per 9.2.2 enclosed as hazabe open to the cooking 19.3.2.5.5 Based on observation failed to maintain 2 ensure cooking facilities were not cooking facilities to maintain 2 ensure cooking facilities where not cooking facilities were not cooking facilities where not cooking facilities includes the facilities were not cooking facilities where not cooking facilities with a cooking facilities and the cooking facilities where not cooking facilities in the cooking facilities with a cooking facilities wit	nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small is microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under .5.3, or in smoke compartments atients comply with 18.3.2.5.4, 19.3.2.5.4. protected according to 3 are not required to be redous areas, but shall not rridor. 1. 18.3.2.5.4, 19.3.2.5.1 5, 9.2.3, TIA 12-2 on and interview, the facility of 4 kitchen corridor doors to lities that serve 30 or more open to the corridor. This effects 50 residents in one	K 0324	orrective action for affected residents: 1. Cart that was blocking the kitchen door was removed and door was immediately closed. How other residents have the potential to be affected:	08/04/2023
	Director on 07/19/2	3 at 12:00 p.m., the main e 30 or more residents, was		Up to 50 residents in 1 smc compartment have the potenti	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21 Facility ID: 012861

If continuation sheet Page 13 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155798		A. BU	A. BUILDING <u>01</u> B. WING			COMPLETED 07/19/2023	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		4111 PA	ADDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE VAYNE, IN 46845		
(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)	ΓE	(X5) COMPLETION DATE
	corridor doors were	due to two of the kitchen blocked from closing due to a oors. Based on interview at			be affected by the alleged defi practice.	cient	
		rvations, the Maintenance doors were blocked from ove the cart.			Measure put into place and systematic changes:		
	The finding was rev	riewed with the Maintenance ministrator during the exit			3. An audit will be completed daily for 6 weeks, 3 times a we for 3 weeks and weekly until 1 compliant.		
	3.1-19(b)				How the corrective action will I monitored:	oe	
					4. Results of this audit will be forwarded to the Quality Committee for review monthly months with a goal of 100% compliance. Once 100% compliance is achieved freque of further review will be determ by the QAPI committee.	ncy	
					Date systemic Changes will be completed:	e	
					Systemic changes for deficien will be complete by 8/4/23	су	
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes	Maintenance and Testing Maintenance and Testing and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a Id readily available.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

61

If continuation sheet Page 14 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155798	B. W.		<u>U I</u>	07/19/2023	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		\dashv
	PROVIDER OR SUPPLIEF			4111 P.	ARK PLACE DRIVE		
ASHTON	I CREEK HEALTH A	AND REHABILITATION CENTER		FORT \	WAYNE, IN 46845		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
1110		system last checked	1	1110		DATE	_
	b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 6 of 6 sprinkler heads in the carport were not loaded and covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show						
			K 0	353	Corrective action for affected	08/04/2023	
					residents:		
					The spider webs were clean	aned	
					off of the sprinklers. Ceilings		
	signs of leakage; sh	all be free of corrosion,			power washed and sprinklers		
		aint, and physical damage; and			in good working order.		
		the correct orientation (e.g., or sidewall). Furthermore, at			How other residents have the		
		kler that shows signs of any of			potential to be affected:		
		be replaced: (1) Leakage (2)					
		ical Damage (4) Loss of fluid in			2. Up to 25 residents and sta		
	_	responsive element (5)			that use the front entrance the		
		g unless painted by the arer. This deficient practice			potential to be affected by the alleged deficient practice.		
	_	nd up to 25 residents that use			aneged denotern practice.		
	the front entrance.	•			Measuress put into place and		
	F. 1				systematic changes:		
	Findings include:				3. An audit will be completed		
	Based on observation	on with the Maintenance			weekly until 100% compliant.		
	Director on 07/19/2	3 at 12:29 p.m., all the sprinkler			, , , , , , , , , , , , , , , , , , , ,		
	_	t outside of the main entrance			How the corrective action will	be	
		t. Based on interview at the			monitored:		
	time of observation, the Maintenance Director confirmed the sprinkler heads in the carport were				4. Populto of this guidit will be		
	loaded with dirt.	ikiei neads iii die earport were			Results of this audit will be forwarded to the Quality		
	louded with thit.				Assurance Committee for revi	ew	
	The finding was rev	viewed with the Administrator			monthly for 6 months with a		
and Maintenance Director during the exit					goalwith 100% compliance ()ne	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21 Facility ID: 012861

If continuation sheet Page 15 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155798	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/19/2023	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ASHTON	CREEK HEALTH	AND REHABILITATION CENTER			VAYNE, IN 46845		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION DATE
me	conference. 3.1-19(b)			mo	100% compliance is achieved frequency of further review will determined by the QAPI committee. Date systemic changes will be completed: 5. Systemic changes for		Sitte
K 0741	NFPA 101				deficiency will be completed by 8/4/23	/	
SS=E Bldg. 01	Smoking Regulations Smoking Regulations Smoking regulations shall include not be provisions: (1) Smoking shall ward, or compart the liquids, combustibused or stored and location, and such signs that read NC posted with the information smoking. (2) In health care of smoking is prohibite prominently placed secondary signs where smoking shall not (3) Smoking by paresponsible shall be (4) The requirement apply where the paragraph shall be smoking shall be where smoking is	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where sted and signs are d at all major entrances, with language that prohibits be required. Set ent of 18.7.4(3) shall not atient is under direct oncombustible material and pe provided in all areas					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

LD6U21

Facility ID: 012861

1

If continuation sheet Page 16 of 18

PRINTED: 08/10/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155798		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/19/2023				
NAME OF PROVIDER OR SUPPLIER ASHTON CREEK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 4111 PARK PLACE DRIVE FORT WAYNE, IN 46845					
		SUMMARY (EACH DEFICIENT REGULATORY OF devices into which shall be readily averaged and smoking is permitted as the smoking is permitted. The smoking is permitted as the smoking policited affect staff the entrance/exit and defined as the smoking include: Upon arrival to the two staff members of the employee entrance/with the Maintenanted smoking on propertic butts on the ground records review at 10 stated, "Tobacco us campus." Based on observation and recond property by staff.	AND REHABILITATION CENTER STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION In ashtrays can be emptied railable to all areas where ted. On, records review, and ty failed to enforce 1 of 1 es. This deficient practice at use the employee foor #6. facility on 07/19/23 at 9:00 a.m., were observed smoking by the exit. Based on observations ce Director at 11:30 a.m., y was evident due cigarette outside exit #6. Based on 0:00 a.m., the smoking policy e is prohibited throughout the interview at the time of ords review, the Maintenance facility is a non-smoking med there was smoking on	K 0	4111 PA FORT V ID PREFIX TAG	ARK PLACE DRIVE	d yee g eted eek	(X5) COMPLETION DATE 08/04/2023	
		The findings were r Administrator and t during the exit conf 3.1-19(b)	he Maintenance Director			How the corrective action will monitored: 4. Results of this audit will be forwarded to the Quality Assurance Committee for revimenthly for 6 months with a gradient of compliance. Once 100 compliance is achieved frequent of further review will be determed by the QAPI committee.	ew oalof % ency nined		

PRINTED: 08/10/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		155798	B. WI	NG		07/19/	2023
NAME OF PROVIDER OR SUPPLIER ASHTON CREEK HEALTH AND REHABILITATION CENTER				4111 P	ADDRESS, CITY, STATE, ZIP COD ARK PLACE DRIVE WAYNE, IN 46845		
(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 APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	=	DATE
					completed: 5. Systemic changes for deficiency will be completed b 8/4/23	у	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: LD6U21 Facility ID: 012861 If continuation sheet Page 18 of 18