PRINTED: 05/30/2023

DEPARTMENT OF HEALTH AND HUN	FORM APPROVED					
CENTERS FOR MEDICARE & MEDICAID SERVICES 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. BU	JILDING	COMPLETED		
	155679	B. WI	NG	05/09/2023		
			CTREET ADDRESS CITY STATE ZID COD	<u> </u>		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
			4430 ELSDALE DR			

4430 ELSDALE DR						
BETHLE	HEM WOODS NURSING AND REHABILITATION	FORT \	FORT WAYNE, IN 46835			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000						
DI-I-						
Bldg		F 0000				
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in	E 0000				
	accordance with 42 CFR 483.73.					
	accordance with 42 CFR 465.75.					
	Survey Date: 05/09/23					
	Facility Number: 000260					
	Provider Number: 155679					
	AIM Number: 100267820					
	At this Emergency Preparedness survey,					
	Bethlehem Woods Nursing and Rehabilitation					
	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 90 and					
	had a census of 75 at the time of this survey.					
	had a census of 73 at the time of this survey.					
	Quality Review completed on 05/10/23					
K 0000						
Bldg. 01						
	A Life Safety Code Recertification and State	K 0000	The creation and submission of			
	Licensure Survey was conducted by the Indiana		this Plan of Correction does not			
	Department of Health in accordance with 42 CFR		constitute an admission by this			
	483.90(a).		provider of any conclusion set			
	G D + 05/00/03		forth in the statement of			
	Survey Date: 05/09/23		deficiencies, or any violation of			
	Facility Number: 000260		regulation. This provider respectfully requests that the 2567			
	Provider Number: 155679		Plan of Correction be considered			
	AIM Number: 100267820		the letter of Credible Allegation.			
			Based on past survey history and			
	At this Life Safety Code survey, Bethlehem		no harm identified to any resident;			
	Woods Nursing and Rehabilitation was found in		this facility respectfully requests a			
	compliance with Requirements for Participation in		desk review in lieu of a post survey			
			<u> </u>			

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

(X6) DATE

TITLE

JoElyn Louise Morris Administrator 05/19/2023

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/09/2023
	ROVIDER OR SUPPLIER HEM WOODS NURSING AND REHABILITATION	4430 EI	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835	Į.
(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 APPROPRIA' DEFICIENCY)	DATE
	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.		revisit on or before May 22, 20)23.
	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 90 and had a census of 75 at the time of this survey.			
	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance shed used to store maintenance supplies and a shed used for storage of paperwork. Quality Review completed on 05/10/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 25 residents on the 300-hall.	K 0211	K 211 It is the practice of this provider to ensure that all corridor means of egresses a	05/22/2023 are

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING <u>01</u> COMPLETED					
		155679		B. WING		05/09/2	
	PROVIDER OR SUPPLIER	SING AND REHABILITATION		4430 El	ADDRESS, CITY, STATE, ZIP COD LSDALE DR VAYNE, IN 46835		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	Based on observation Director and the Fie 05/09/23 at 11:08 at contained a dresser, a mattress taking up Based on an interviethe Maintenance Distored on the 300-hawere removed.	on with the Maintenance eld Maintenance Supervisor on .m., the 300-hall exit corridor trashcan not on wheels, and two feet of corridor width. ew at the time of observations, rector agreed there were items all exit corridor and the items viewed with the Administrator, Supervisor, and Maintenance exit conference.		TAG	continuously maintained free of all obstructions. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The items found on 300 hall of survey (dresser, trashcan on wheels, and a mattress) we all removed immediately on 5/9 How other resident having the potential to be affected by the alleged deficient practice will be identified a what corrective action wheels to be affected by the alleged deficient practice. All residents have to potential to be affected by the alleged deficient practice. All corridor means of egresses	he during not ree /23.	DATE
					in facility are free of obstruct Department head personnel made sure	ions.	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155679	(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 05/09/2023
	ROVIDER OR SUPPLIEI HEM WOODS NUF	RSING AND REHABILITATION	4430 I	ADDRESS, CITY, STATE, ZIP COD ELSDALE DR WAYNE, IN 46835	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE
	ALGOLING OF THE PARTY OF THE PA			Of this on May 9th Daily Life Safety Code rounds are performed to enthat all corridor means of egresses are continuously kept free of obstructions. All staff in-servicing was completed as of May 2 2023 to ensure that all employee aware of the importance and necess ensuring that all means of egresses are to be continuously maintained all obstructions for full use in emergency. What measures be put into place and what systemic changes will be made to ensure that the	h. Isure f I2nd, s are ity of I free of case of
				deficient practice does not recur: Daily Life Safety rounds sheets are utilized of These daily round sheets we include ensuring that all corridor me of egresses are free	Code daily. will
				of egresses are free of all obstructions Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director	

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155679	B. W	NG _		05/09	/2023
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ELSDALE DR		
BETHLE	HEM WOODS NUR	SING AND REHABILITATION			WAYNE, IN 46835		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Nursing are		
					responsible to collect and revi	ew	
					these rounds		
					sheets consistently and ensure	е	
					any areas found		
					needing attention will be		1
					addressed immediately.		
					This will include ensuring that	all	
					corridors		
					are barrier free. Administrator	and	
					Director of		
					Nursing and other Department	tal	
					Leaders		
					will also perform daily rounds.		
					How the corrective		
					action will be		
					monitored to ensure the		
					deficient		
					practice will not recur, i.e.		
					what		
					quality assurance program w	vill	
					be		
					put into place:		
					To ensure compliance,		
					the Administrator and/or Desig	jnee	1
					Will		
					ensure that daily rounds are		
					occurring and		
					the round sheets are turned in	1	
					daily. The results of these daily rounds a	nd	1
						iid	
					the observations and corrections		
					identified will	•	1
					be reviewed by the Leadership	þ	
	I		1		Team at		1

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morning

least 5 days out of 7 at the daily

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	OF CORRECTION	IDENTIFICATION NUMBER 155679	A. BUILDING B. WING	01	COMPLETED 05/09/2023
	ROVIDER OR SUPPLIER	SING AND REHABILITATION	4430 El	ADDRESS, CITY, STATE, ZIP COD LSDALE DR VAYNE, IN 46835	į.
(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
14 0000				meeting. Repetitive concerns found will be addressed via re- in-servicing follow up. Results of these daily rounds who be reviewed at the monthly QAPI meetings overseen by the Administrator. By what date the systemic changes will be completed: May 22, 2023	
K 0232 SS=E Bldg. 01	unobstructed) servat least 4 feet and	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the all of nonambulatory patients ept as modified by			
	Based on observation failed to meet the cle corridors or met and 19.2.3.4(5) states which least 8 feet, projection shall be permitted for all of the following (a) the fixed furnitual floor or to the wall. (b) the fixed furnitual unobstructed corridor except as permitted	re is securely attached to the re does not reduce the clear or width to less than six feet,	K 0232	K 232 It is the practice of this provider to meet the clear wide requirement for all corridors. What corrective action will be accomplished for those residents found to have	or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPL	
		155679	B. W	ING		05/09/	/2023
NAME OF I	PROVIDER OR SUPPLIE	D		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	K		4430 E	LSDALE DR		
BETHLE	HEM WOODS NUF	RSING AND REHABILITATION		FORT \	WAYNE, IN 46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of the corridor.				deficient practice:		
	` '	ure is grouped such that each			Two chairs and a desk		
		exceed an area of 50 square			that were in the ma	in	
	feet.				entrance were		
	* *	are groupings addressed in			removed on 5/9/23	and	
		separated from each other by a			5/10/23.		
	distance of at least	- *			No residents were		
	\ /	are is located so as to not			affected.		
		building service and fire					
	protection equipme				How other residen	ts	
		ghout the smoke compartment			having		
		electrically supervised			the potential to be		
	automatic smoke detection system in accordance				affected		
		fixed furniture spaces are			by the alleged		
		ed to allow direct supervision			deficient practice		
		from a nurse's station or similar			will be identified ar	nd	
	space.				what		
		partment is protected			corrective action w	<i>r</i> ill	
		pproved, supervised automatic			be taken:		
		accordance with 19.3.5.8			No residents were affected by	/ this	
	_	tice could affect 20 residents			practice,		
	using the main entr	rance.			however the potential existed	l for	
					all residents		
	Findings include:				to be affected. No		
					furniture will be placed		
		on with the Maintenance			in the front main		
		eld Maintenance Supervisor on			entrance, unless it abides with		
		a.m., two chairs and a desk were			the Life Safety Cod	е	
		the main entrance and			regulation of being fixed		
		o feet into the corridor and were			furniture that is		
		loor or to the wall when tested.			securely attached to the floor	or	
	Based on interview				wall, and does not		
		Maintenance Director agreed			reduce the clear unobstructed		
		were not securely attached to			corridor width to les	s	
	the floor or to the v	wall when tested.			than six feet, along with		
					all other legal requirements.	The	
		eviewed with the Administrator,			main entrance will be		
		Supervisor, and Maintenance			checked daily for		
	Director during the	e exit conference.			compliance to this regulation	by	
					utilizing a daily Life		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155679	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/09/2023
	PROVIDER OR SUPPLIE	R RSING AND REHABILITATION	4430 E	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			Safety Code rounds sheet checkoff list. All staff in-servicin was completed as of May 22 2023 to ensure that all employees aware of the importance and necessit ensuring that the main entra to be continuously maintained all unsecured furniture, desks, or any other obstructions to allow for full use in case of emergence. What measures we	are y of nce is free of er
				be put into place and what systemic changes will be made to ensure that the	
				deficient practice does not recur: Daily rounds sheet are utilized daily. These daily round sheets will include ensigned that all corridor metors of egresses are free of all obstruction, including the Main entryway. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and retthese rounds sheets daily and ensure any	y suring eans f view

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155679	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/09/2023
	ROVIDER OR SUPPLIE HEM WOODS NUF	R RSING AND REHABILITATION	4430 E	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835	
(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
				found needing attention will be addressed and fixed immediately. This will include ensuring that corridors are barrier free and within regulation, including the main entryway. Administrator Director of Nursing and other Department Leaders will also perform daily rounds.	and
				How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program w	
				be put into place: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what	
				quality assurance program we be put into place: To ensure compliance, the Administrator and/or Designwill ensure that Life Safety Code of rounds are occurring and the round sheets are turned in daily. The results of these daily round and the	gnee daily s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155679 B. WING		ILDING	ONSTRUCTION 01	(X3) DATE COMPI 05/09	LETED		
	PROVIDER OR SUPPLIE	R RSING AND REHABILITATION		4430 E	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835	1	
(X4) ID PREFIX TAG	(EACH DEFICIE)	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)	ATE	(X5) COMPLETION DATE
		K LSC IDENTIFTING INFORMATION		IAU	observations and corrections identified will be reviewed by the Leadershi Team at least 5 days out of 7 at the da morning meeting. Repetitive concerns found will be addressed via re- in-servicing follow up. Results of these daily rounds be reviewed at the QAPI meetings oversee the Administrator. By what date the systemic changes For each deficiency will be completed:	and	DATE
K 0293 SS=E Bldg. 01	accordance with illumination also slighting system. 19.2.10.1 (Indicate N/A in o occupancies with where the line of Based on observatifailed to ensure 1 cmarked as an exit. required the means accordance with So	al signs are displayed in 7.10 with continuous served by the emergency ne-story existing less than 30 occupants exit travel is obvious.) on and interview, the facility of 7 exit doors were properly LSC 7.10.1.1 states where of egress shall be marked in exition 7.10 where required in the 43. This deficient practice	K 02	293	K 293 It is the practice of this provider to always ensure th all exit doors are properly marked as exits.	at	05/22/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 B. WING		COMPLETED 05/09/2023	
		155679	B. W	ING		05/09/2023	
	PROVIDER OR SUPPLIER	SING AND REHABILITATION		4430 EI	ADDRESS, CITY, STATE, ZIP COD LSDALE DR NAYNE, IN 46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DI ANI OF CODDECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	could affect 25 resid	dents on the 300-hall.					
	could affect 25 residence Findings include: Based on observation Director and the Field of the 30 door there was an "I of the door there was Based on interview observations, the M door is an exit and the visitors so they would the "NOT AN EXITATION TO THE "NOT AN EXITATION TO THE STATE OF THE TO THE STATE OF THE TO	on with the Maintenance eld Maintenance Supervisor on a.m., conflicting signage was O-hall exit door. Above the EXIT" sign and in the middle as a "NOT AN EXIT" sign. at the time of the aintenance Director stated the the "Not An Exit" sign was for ald only use the main entrance. T" sign was removed.			What corrective action will be accomplished for those residents found to have been affected by th deficient practice: No residents were affected. All residents on 300 hall had the potential to affected. The "Not an Exit" sign was immediately removed during to Survey on May 9th from the 300 hall Exit door. How other resident having the potential to be affected by the alleged deficient practice will be identified an what corrective action w be taken: No residents were affected. All residents in the building have the potential to be affect by conflicting signage on Exit doo On the day of the survey, May 9th, all exit doors were checked to	be he ts ted rs.	
					ensure that no "Not an Exit" si	an	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/09/2023	
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NUR	SING AND REHABILITATION	4430 E	ADDRESS, CITY, STATE, ZIP COD LSDALE DR NAYNE, IN 46835		
PREFIX (EACH DEFICIENCE	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 APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE	
			or any conflicting signage existed on a of the exit doors.	any	
			What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily Life Safety Co rounds sheets are utilized daily. These daily rounds she will include ensuring that all exit doors hat correct exit signage with no other conflicting exit information or signage. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and reviet these rounds sheets daily and ensure any a found needing attention will be addressed and fixed immediately. This will include ensuring that corridors are barrier free and within regulation, including the main entryway, and that no conflicting Exit signage information exists on any of the exit doors Administrator and Director of	de ets ve ew reas	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 5	(X3) DATE SURVEY COMPLETED 05/09/2023	
	PROVIDER OR SUPPLIER	SING AND REHABILITATION	4430 E	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835	
(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
me	KLGCL/HOKT OF	ESC IDENTIFY THE INFORMATION	17.0	Nursing and other Departmenta Leaders will also perform daily rounds to ensure compliance.	al
				How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: To ensure compliance, the Administrator and/or Design will ensure that daily rounds are occurring and the round sheets are turned in daily. The results of these daily rounds and the observations and corrections identified will be reviewed by the Leadership Team at least 5 days out of 7 at the daily morning meeting. Repetitive concerns found will be addressed via re- in-servicing and the definition of the design of the design of the daily morning meeting.	nee d
				follow up. Results of these daily rounds w be reviewed at the QAPI meetings overseen the Administrator.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/09/2023			LETED		
	PROVIDER OR SUPPLIE HEM WOODS NUF	R RSING AND REHABILITATION		4430 E	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
					By what date the systemic changes For each deficiency will be completed: May 22, 2023		
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with Inspection, Testir Water-based Fire Records of systel inspection and te secure location a a) Date sprinkle b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observati failed to ensure the sprinkler heads we with LSC 19.3.5.1. 8.5.5.1 states sprin minimize obstructi Section 8.5.5.2 and sprinklers shall be	RKS information on non-required or partial er system. If, and NFPA 25 on and interview, the facility spray pattern for 1 of 1 re not obstructed in accordance NFPA 13, 2010 edition, Section klers shall be located so as to ons to discharge as defined in a Section 8.5.5.3 or additional provided to ensure adequate	K 0:	353	K 353 It is the practice of the provider to ensure the spray pattern of all sprinkler heads is not obstructed. What corrective		05/22/2023
	do not permit conti	eard. Sections 8.5.5.2 and 8.5.5.3 nuous or noncontinuous an or equal to 18 inches below			action will be accomplished f those	or	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	- 1	MPLETED
		155679	B. W	ING		05/	09/2023
NAME OF P	DOMDED OF CURPUSE			STREET A	ADDRESS, CITY, STATE, ZIP CO)D	
NAME OF P	PROVIDER OR SUPPLIER			4430 EI	LSDALE DR		
	HEM WOODS NUR	SING AND REHABILITATION	T	FORT V	WAYNE, IN 46835		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	-	tor or in a horizontal plane			residents fou	ind to	
		s below the sprinkler deflector			have	J h 4h -	
		ay pattern from fully			been affected	-	
	residents around the	efficient practice could affect 5			deficient prac		
	residents around the	marketing office.			No residents affected.	were	
	Findings include:				απесτεα. The items in t	·ho	
	rmamgs metude:					.i i C	
	Rased on observation	on with the Maintenance			marketing office closet's top shelf were	removed	
		eld Maintenance Supervisor on			immediately	ieilioveu	
		.m., the closet in marketing			during the survey on M	av 0th	
		red about 4 to 6 inches away			In addition, the top she	-	
		sprinkler head. Based on			itself in the ma		
		e of observation, the			office closet was	antomig	
		for agreed the items were less			removed on May 17th, 2	2023	
		the sprinkler and would			so that nothin		
	obstruct sprinkler co	-			stored to come	J	
	•	_			anywhere close to the s	prinkler	
	This finding was re	viewed with the Administrator,			head	•	
	_	Supervisor, and Maintenance			in that closet.		
	Director during the	exit conference.					
					How other re	sidents	
	3.1-19(b)				having		
					the potential	to be	
					affected		
					by the alleged	d	
					deficient practice		
					will be identif	ned and	
					what	tion will	
					corrective ac	uon Will	
					No residents v	were	
					affected.	wele	
					All residents of	could be	
					affected by any	Joula DC	
					obstructed sp	rinkler	
					heads. A whole		
					house check	was	
					performed on May 16th		
					that	,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/09/2023	
	ROVIDER OR SUPPLIEI HEM WOODS NUF	RSING AND REHABILITATION	4430 E	ADDRESS, CITY, STATE, ZIP COD ELSDALE DR WAYNE, IN 46835	
(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
				no sprinkler heads were obstructed in any location. All were for to be clear of obstruction.	und
				What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily Life Safety Corounds sheets are utilized dail These daily rounds sheets will include ensuring that no sprinkler head in the facility are obstructed by anything within 18 inches of the ceiling. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and reviet these rounds sheets daily and consistently a ensure any areas found needing attention be addressed and fixed immediately. This will include ensuring that corridors are barrier free and within regulation, including the main entryway, no conflicting I signage exists, and no obstructions are within 18	de y. Il ads v ew and n will

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T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155679	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/09/2023	
ROVIDER OR SUPPLIER	SING AND REHABILITATION	4430 E	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835		
HEM WOODS NUR SUMMARY S (EACH DEFICIEN		4430 E	LSDALE DR	tal vill gnee nd builty and	
			be reviewed at the QAPI meetings oversee the Administrator.	n by	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURY A. BUILDING 01 COMPLETED					
		155679	B. WI			05/09/	2023
	PROVIDER OR SUPPLIEI	RSING AND REHABILITATION		4430 EL	ADDRESS, CITY, STATE, ZIP COD LSDALE DR VAYNE, IN 46835		
(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)	TE	(X5) COMPLETION DATE
					By what date the systemic changes For each deficiency will be completed: May 22, 2023		
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade relocations and whe anesthesia is adminitial installation, Additional testing defined by docum Receptacles not lithese locations ar exceeding 12 more (LIM), if installed, less than or equal the LIM test switch activates both visually LIM circuits with a manual test is per than or equal to 1 tested per 6.3.3.3 renovation to the Records are main associated repairs containing date, results. 6.3.4 (NFPA 99) Based on observation	s - Maintenance and s - Maintenance and ceptacles at patient bed ere deep sedation or general ninistered, are tested after replacement or servicing. is performed at intervals nented performance data. isted as hospital-grade at re tested at intervals not nths. Line isolation monitors are tested at intervals of I to 1 month by actuating th per 6.3.2.6.3.6, which ual and audible alarm. For automated self-testing, this rformed at intervals less 2 months. LIM circuits are 8.2 after any repair or electric distribution system. ntained of required tests and s or modifications, oom or area tested, and on, record review and ity failed to ensure non-hospital	K 00	914	K 914 It is the practice of thi	S	05/22/2023
	interview, the facili	ity failed to ensure non-hospital eptacles at 50 of 50 resident re tested at least annually.	K 0.)1 1	provider to ensure that all non-hospital grade	9	03/22/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 01 COMPLET B. WING 05/09/20		LETED				
		PROVIDER OR SUPPLIEI	RSING AND REHABILITATION		4430 EI	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835	•	
	(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	ATE	COMPLETION
	TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	416	DATE
		NFPA 99, Health C	Care Facilities Code 2012 Edition,			receptacles in all 50	of	
		Section 6.3.4.1.3 states receptacles not listed as				50 resident		
		hospital-grade, at p	atient bed locations and in			sleeping rooms are		
		locations where de	ep sedation or general			tested and documented		
			nistered, shall be tested at			as such at least annually.		
		intervals not exceed	ding 12 months. Additionally,					
			ceptacle Testing in Patient Care			What corrective		
			e physical integrity of each			action will		
		-	confirmed by visual inspection.			be accomplished f	or	
		The continuity of the grounding circuit in each				those		
	electrical receptacle shall be verified. Correct				residents found to			
	polarity of the hot and neutral connections in				have			
	each electrical receptacle shall be confirmed; and				been affected by the	ne		
	retention force of the grounding blade of each				deficient practice:			
			e (except locking-type			All non-hospital gra	de	
		-	e not less than 115 grams (4			receptacles in	uo	
			ient practice could affect all			50 of 50 resident ro	oms	
		residents.	rent praestee coura arreet air			have been tested	01113	
		residents.				with documented		
		Findings include:				results as of May 18, 2023.		
		i mamga meraac.				Those few found ou	ıt of	
		Based on observati	ons during a tour of the facility			compliance were replaced.	11 01	
			ace Director and Field			Final testing results		
			rvisor on 05/09/23 between			showed all receptacles tested		
		_	0 p.m., the facility's 50 resident			and in compliance		
		sleeping rooms eac				regulation.	poi	
			electrical receptacles. Based			Togalation.		
			at 10:30 a.m., no documentation			How other residen	ts	1
			ow the last time the electrical			having	13	
			ent sleeping rooms were			the potential to be		
		-				affected		
	tested. Based on interview at the time of the observation and records review, the Field				by the alleged			
			visor confirmed all the			deficient practice		
		_	es in the resident sleeping			will be identified a	nd	
		•	spital-grade and stated it is			what	ıu	
						corrective action w	/ill	
	unknown the last time the annual testing was completed.				be taken:	7111		
		completed.				No residents were		
		This finding was re	eviewed with the Administrator,					
		_	Supervisor, and Maintenance			affected, but all residents had the		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED
		155679	B. WI		05/09/2023	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
DETULE!		SING AND DEHABILITATION			LSDALE DR	
DEIHLE	HEINI MOODS NUR	SING AND REHABILITATION	_	FORT	VAYNE, IN 46835 	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG		DATE
	Director during the	exit conference.			potential to be affected. The	
	3.1-19(b)				Maintenance Field	
	3.1 17(0)				Supervisor in-servic	ed
					two departmental	
					leaders on how to	
					properly test the non-	
					hospital grade	
					receptacles, what testing	
					machine to use, and how	
					to do the appropriate documentation.	5
					Those two leaders t	hen
					tested all resident	
					room receptacles to	
					ensure receptacles	
					tested within required limits. T	his
					task is	
					listed in the TELS Preventative	e
					Maintenance	
					computer system and will trigg	ger
					the Maintenance Supervisor or	
					Administrator's	
					Designee to accomplish this	
					required receptacle	
					testing and documentation	
					annually.	
					What measures wil	ı İ
					be put into	
					place and what	
					systemic changes	
					will be made to	
					ensure that the	
					deficient practice	
			1		does not recur:	

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	NT OF DEFICIENCIES	f f		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED 05/09/2023		
		155679	B. W			05/09/20	123	
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
DETULE	HEM WOODS NILID	ISING AND DELIADII ITATIONI			LSDALE DR			
DEIALE	THEINI WOODS NUR	SING AND REHABILITATION		FURI	WAYNE, IN 46835 			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	+	TAG			DATE	
					Daily Life Safety rounds sheet are utilized daily.	5		
					These daily round sheets will			
					include ensuring			
					the visible integrity of all reside	ent		
					room receptacles.			
					Any issues found during the			
					rounds will be addressed			
					Immediately. The Administrate	or or		
					Designee will check			
					The TELS reports to ensure			
					compliance with			
					all tasks assigned prior to eac QAPI meeting.	n		
					Re-inservicing for all staff			
					was completed			
					effective May 22, 2023.			
					Administrator and Director of			
					Nursing are			
					responsible to collect and revi	ew		
					these rounds			
					sheets daily and consistently a	and		
					ensure any			
					areas found needing attention	ı Will		
					be addressed			
					and fixed immediately. This will include ensuring that	all		
					corridors ,	un		
					including the main entryway, a	ıre		
					barrier free			
					and within regulations, no			
					conflicting Exit signage exists,			
					all sprinkler heads in the facili	ty		
					are free of obstructions,			
					and the visible integrity of			
					receptacles is intact.			
					Administrator and Director of			
					Nursing and other Departmen	iai		
					Leaders will perform daily rounds			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		ULTIPLE CONSTRUCTION JILDING O1 ING	(X3) DATE SURVEY COMPLETED 05/09/2023
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REF	HABILITATION	STREET ADDRESS, CITY, ST. 4430 ELSDALE DR FORT WAYNE, IN 468	
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL	PREFIX (EACH CORRECTION CROSS-REFERENCE)	PLAN OF CORRECTION WE ACTION SHOULD BE ED TO THE APPROPRIATE PICIENCY) CX5) COMPLETION DATE
		action will be monitored to deficient practice will r what quality assurabe put into place To ensure conthe Administrativill ensure that da occurring and the round sheet daily. The results of these the observations a identified will be reviewed be Team at least 5 days of morning meeting. Repfound will be addressed via follow up, and disciplinatine necessary. The Administrative check The TELS repcompliance will tasks assig QAPI meeting	ance program will : inpliance, tor and/or Designee illy rounds are ets are turned in e daily rounds and and corrections by the Leadership at of 7 at the daily etitive concerns re- in-servicing and by action when eator or Designee will orts to ensure th ned prior to each

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED 05/09/2023	
	PROVIDER OR SUPPLIER	SING AND REHABILITATION	443	EET ADDRESS, CITY, STATE, ZIP CO 60 ELSDALE DR RT WAYNE, IN 46835	DD .
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETION DATE
				at the QAPI meetings of the Administrator.	verseen by
				By what date the syste changes For each deficiency wi completed: May 22, 2023	
K 0920 SS=E Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vi- non-PCREE (e.g., except in long-terr do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re- other UL standard used with general cords are not used wiring of a structur temporarily are re- completion of the installed and meet 10.2.3.6 (NFPA 98)	ent - Power Cords and ent - Power Cords and ent - Power Cords and patient care vicinity are only ints of movable defectrical equipment des that have been diffied personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE of UL 60601-1. Power strips the patient care rooms meet UL 1363. In poms, power strips meet s. All power strips are precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was as the conditions of 10.2.4. d), 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155679	B. WING			05/09/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					LSDALE DR		
BETHLEHEM WOODS NURSING AND REHABILITATION					NAYNE, IN 46835		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CONTROLLING THE INDICATION	_		T	<u> </u>	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ON
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		 	TAG	DEFICIENCY)	DATE	
	l '	ervation and interview, the	K 0	920	K 920 It is the practice of thi	05/22/202	23
	1	sure 1 of 1 multi-plug adaptors			provider		
		abstitute for fixed wiring. LSC			to ensure that		
		rical wiring and equipment shall ith NFPA 70, National			multi-plug adapters		
		FPA 70, 2011 Edition, Article			are not used as a		
		unless specifically permitted,			substitute for	vor	
	*	ables shall not be used as a			fixed wiring, and pov	ACI	
		wiring of a structure. This			strips are not used as a		
		ffects 5 residents outside of the			substitute for fixed		
	Activities office.	rices 5 residents outside of the			wiring to provide por	wer	
	Tietry tries office.				equipment	101	
	Findings include:				with a high current		
					draw.		
	Based on observation	on with the Maintenance					
	Director and the Fig	eld Maintenance Supervisor on			What corrective		
		.m., multi-plug adaptor powering			action will		
	computer equipment was being used in the				be accomplished for	r	
	Activities office. Based on interview at the time of				those		
	observation, the Maintenance Director and agreed				residents found to		
	a multi-plug adapto	r was in use in the Activities			have		
	office.				been affected by th	e	
					deficient practice:		
					On May 9th, during survey,		
	#2.) Based on observation and interview, the				the multi-plug adapt	er	
	facility failed to ensure 1 of 1 power strips were				in the Activity Office		
	not used as a substitute for fixed wiring to provide				was removed. Nothing will be		
	power equipment with a high current draw. This				plugged in		
	deficient practice could affect up to 5 residents				unless it is plugged into the wa	All	
	outside of the DON office.				directly		
	Findings include:				or into a medical grade		
	rindings include:				approved.device. Also, on		
	Based on observation with the Maintenance				May 9th, during survey, the refrigerator in the		
	Director and the Field Maintenance Supervisor on				Director of Nursing's office wa		
	05/09/23 at 12:18 p.m., a refrigerator (high power				moved to an		
	draw equipment) was plugged into and supplied				area where it could be directly		
	power by a power strip in the DON office. Based				plugged into the		
	on interview at the time of observation, the				fixed wiring wall receptacle.		
	Maintenance Director acknowledged a power strip						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/09/2023	
	PROVIDER OR SUPPLIE	R RSING AND REHABILITATION	4430 E	ADDRESS, CITY, STATE, ZIP COD ELSDALE DR WAYNE, IN 46835	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	equipment. The findings were Administrator, Fie	reviewed with the ld Maintenance Supervisor, and etor during the exit conference.		How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken: No residents were affected by this practice. All residents could have been affected by this practice. A whole house audit May 16th was done to ensure that no non-medical grade power devices were being used or being used incorrectly. All high current draw power equipment is plugged directly into the fixed wiring receptacles. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily Life Safety Coorounds sheets are utilized daily These daily round sheets will include ensuring	d III

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/09/2023	
NAME OF PROVIDER OR SUPPLIER BETHI FHEM WOODS NURSING AND REHABILITATION				4430 EI	ADDRESS, CITY, STATE, ZIP COD LSDALE DR WAYNE, IN 46835		
(X4) ID PREFIX TAG	DF PROVIDER OR SUPPLIER LEHEM WOODS NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIE			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) that all powered devices and equipment are plugged into the regulation approved receptacles. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and revi these rounds sheets daily and consistently ensure any areas found needing attention be addressed and fixed immediately. This will include ensuring that corridors, including the main entryway, a barrier free and within regulations, no conflicting Exit signage exists all sprinkler heads in the facil are free of obstructions, the visible integrity of recepta is intact, and all powered devices are plugged into regul approved receptacles. Administrator and Director of Nursing and other Department Leaders will perform daily rounds.	iew and n will are , lity acles	(X5) COMPLETION DATE

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deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155679		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/09/2023			
NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP COD 4430 ELSDALE DR FORT WAYNE, IN 46835					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)		TE	(X5) COMPLETION DATE	
					practice will not recur, i.e. what quality assurance program who be put into place: To ensure compliance, the Administrator and/or Designal will ensure that daily Life Safety rounds are occurring and the round sheets are turned in daily. The results of these daily rounds at the observations and corrections identified will be reviewed by the Leadership Team at least 5 days out of 7 at the dail morning meeting. Repetitive concerns found will be addressed via re- in-servicing follow up. Results of these daily rounds who be reviewed at the QAPI meetings overseed the Administrator. By what date the systemic changes For each deficiency will be completed: May 22, 2023	gnee nd o ily and will		

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