STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155658	A. BUILDING -- B. WING	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEY MANOR HEALTH CENTER	1555 N MAIN ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/20/23 Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 At this Emergency Preparedness survey, Wesley Manor 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 96 certified beds. At the time of the survey, the census was 86. Quality Review completed on 04/26/23	E 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on May 17, 2023.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gary "BRENT" Waymire	Executive Director / Administrator	05/05/2023

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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	Survey Date: 04/20/23 Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 At this Life Safety Code survey, Wesley Manor Health Center was found not in compliance with Requirements for Participation in 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. This facility was surveyed as two buildings because of different construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement was determined to be Type II (222) construction. The G and H wings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility has a capacity of 96 and had a census of 86 at the time of this survey. All areas which provide customary access to residents were sprinklered. All areas which provide facility services such as the laundry, generator room, boiler room and the maintenance department were not sprinklered. Quality Review completed on 04/26/23		these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on May 17, 2023.	
K 0000 Bldg. 02				

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	155658	A. BUILDING 02 B. WING	04/20/2023

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	A Life Safety Code Recertification and State Licensure survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/20/23 Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 At this Life Safety Code survey, Wesley Manor Health Center was found not in compliance with Requirements for Participation in 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. This facility was surveyed as two buildings because of different construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement was determined to be Type II (222) construction. The G and H wings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in resident rooms. The facility has a capacity of 96 and had a census of 86 at the time of this survey. All areas which provide customary access to residents were sprinklered. All areas which provide facility services such as the laundry, generator room, boiler room and the maintenance department were not sprinklered.	K 0000	Wesley Manor considers itself a partner with regulatory agencies and others who monitor the quality of care and services, and we welcome feedback received by these entities to continually improve the care and services that we provide. We submit this Plan of Correction in recognition of the importance of receiving this feedback to continually refine our practices. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Wesley Manor desires this Plan of Correction to be considered our Allegation of Compliance. Compliance is effective on May 17, 2023.	

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	Quality Review completed on 04/26/23			
K 0311 SS=E Bldg. 02	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure the protection of 1 of 2 vertical openings in accordance with 19.3.1. LSC 19.3.1.1 states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. LSC 8.3.4.2 states the fire protection rating for opening protectives shall be in accordance with Table 8.3.4.2 except as otherwise permitted in 8.3.4.3 or 8.3.4.4. Table 8.3.4.2 requires fire door assemblies in vertical shafts, including stairways, to have a 1-hour fire resistance rating. LSC 8.3.4.3 states existing fire door assemblies having a minimum ¾-hour fire protection rating shall be permitted to continue to be used in vertical openings and exit enclosures in lieu of the minimum1-hour fire protection rating required in Table 8.3.4.2. This deficient practice could affect as many as 18 residents, 6 staff and 2 visitors within the facility. Findings include: Based on observations made during a tour of the	K 0311	It is the policy of Wesley Manor to assure vertical openings – enclosure, such as stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating in accordance with the life safety code. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The elevator separation door labeled as G 103 was adjusted immediately following the life safety visit on April 20, 2023, so that it would fully close and latch. See the attached photo – Attachment – K 311 – A. *How will the facility identify other residents having the potential to*	05/17/2023

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	facility with the Maintenance Director on 04/20/23 at 1:24 p.m., the second-floor elevator separation door labeled as G 103 failed to fully close and latch leaving a 1-inch gap when the door was closed to its fullest. This was verified by the Maintenance Director at the time of observation who added that he would have his staff address the issue immediately. 3.1-19(b)		*be affected by the same alleged deficient practice?* An audit was completed on April 21, 2023, of all the fire doors located in the community, to verify that all doors fully closed and latched. See the attached audit – Attachment – K 311 – B. The audit found no other fire doors affected. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor will continue its practice of inspecting fire doors monthly. Doors which are found that do not fully close, latch, or meet the provisions of the life safety code will be repaired immediately upon discovery. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? Through routine and random rounds, the Maintenance Director will review Fire Doors to assure that they close fully, latch and meet the applicable requirements of the life safety code. The results of the Fire Door Monthly Inspection audits for the previous month will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) for Safety which is held one time monthly for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or	

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			lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window			

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	assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching, and would resist the passage of smoke. This deficient practice could affect 30 residents, 10 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the Maintenance Director on 04/20/23 at 1:24 p.m., the second-floor kitchen door to the corridor had a kick stop mounted on the bottom of the door. This was holding the door to the corridor, a door that had a self-closing device mounted on it, in the open position. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door as being propped in the fully open position with a door wedge and stated that he would have it removed as soon as possible. 3.1-19(b)	K 0363	It is the policy of Wesley Manor to ensure corridor doors protecting corridor openings meet the applicable provisions of the life safety code. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The kick stop mounted to the kitchen door labeled as G 1110 was removed immediately following the life safety visit on April 20, 2023, so that it could not be propped open again. See the attached photo – Attachment – K 363 – A. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* An audit was completed on May 1, 2023, of all the hazard area doors located in the community, to verify that all doors had no kick stand type device installed on them and that they met the intent of the life safety code. See the attached audit – Attachment – K 363 – B. The audit found no other hazard area doors affected. What measures will be put into	05/17/2023

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			place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor will continue its practice of inspecting hazard area doors monthly. Doors which are found that do not meet the provisions of the life safety code will be repaired immediately upon discovery. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? Through routine and random rounds, the Maintenance Director will review Hazard Area Doors to assure that they do not contain a kick stop device and are not propped open and meet the applicable requirements of the life safety code. The results of the Hazard Area Door Monthly Inspection audits for the previous month will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) for Safety which is held one time monthly for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire			

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	alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of the document titled "Fire Drill Report" with the Maintenance Director on 04/20/23 at 9:40 a.m., the documentation for the drills for the past twelve months lacked verification of the transmission of the signal for drills. Based on interview at the time of record review, the Maintenance Director stated that he did ask the monitoring company for confirmation of the signal being received during his drills but failed to document the verification of the transmission of the fire alarm signal in his records. 3.1-19(b) 3.1-51(c)	K 0712	It is the policy of Wesley Manor to ensure fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, as well as other provisions of the life safety code. *How will corrective action be accomplished for those residents found to have been affected by the alleged deficient practice?* The Wesley Manor Fire Drill Report has been revised to include an area to record the verification of the transmission of the signal for drills to the monitoring company. See the attached form, Attachment – K 712 – A. *How will the facility identify other residents having the potential to be affected by the same alleged deficient practice?* All residents have the potential to be affected by the alleged deficiency. What measures will be put into place or systematic changes made to ensure that the alleged deficient practice will not recur? Wesley Manor will continue to	05/17/2023

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			conduct fire drills in accordance with the provisions of the life safety code. The revised Fire Drill Report now contains an area to record the verification of the transmission of the signal for drills to the monitoring company. The designated personnel conducting the drill will record the verification information from the alarm monitoring company on the revised form. How will the facility monitor its corrective actions to ensure that the alleged deficient practice will not recur? The Fire Drill Reports for the previous month will be reported in the QAPI Subcommittee Meeting (MEGA Meeting) for Safety which is held one time monthly for the next three months and reported to the QAPI Committee Quarterly. Depending on the progress, or lack thereof, the QAPI Committee will determine the reporting frequency on a go forward basis.	