STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155755	A. BUILDING -- B. WING	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

(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: 10/10/24 Facility Number: 000282 Provider Number: 155755 AIM Number: 100287520 At this Emergency Preparedness survey, Golden Years Homestead 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 111 and had a census of 99 at the time of this survey. Quality Review completed on 10/16/24	E 0000		
E 0026 SS=F Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(Roles Under a Waiver Declared by Secretary Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all residents and staff. Findings include:	E 0026	Facility will implement a policy to establish roles for providing care and services under a waiver declared by the Secretary in accordance with Section 1135 of the Act. The Leadership Team of Facility will receive in-service training of the policy. The policy will be kept with all emergency disaster preparedness manuals. The in-service education will be provided by the Director of	11/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
steve	schaaf	10/31/2024

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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	Based on record review with the Director of Maintenance and Maintenance Supervisor from 9:30 a.m. to 12:08 p.m. on 10/10/24, a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review. Based on interview at the time of record review, the Director of Maintenance and Maintenance Supervisor stated they were not able to locate a policy regarding the facility's role under a waiver declared by the Secretary in accordance with section 1135 of the Act. This finding was reviewed with the Director of Maintenance and Maintenance Supervisor at the exit conference.		Maintenance. The Quality Assurance (Q.A.) Committee will evaluate the effectiveness of policy implementation through a review of related observations and documentation for a period of six months. Any deviation from the policy will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the Q.A. Committee.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	The documentation of one table-top exercise to test the emergency plan was located after the LSC surveyor exited the Facility. A second exercise--an annual facility-based functional exercise involving a simulated tornado watch and warning and hotwash of the exercise-will be conducted to test the emergency plan by the Director of Maintenance and Administrator. The Director of Maintenance and Maintenance Supervisor will receive in-service training covering regulatory requirements under E039 related to Emergency Plan testing requirements for long term facilities at §483.73(d). The	11/05/2024

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	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Maintenance and Maintenance Supervisor from 9:30 a.m. to 12:08 p.m. on 10/10/24, the facility was not able to provide documentation of a table-top exercise or a full-scale community-based exercise, a facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan. Based on interview at the time of record review the Director of Maintenance stated a Table-top exercise was completed but no documentation was provided. This finding was reviewed with the Director of Maintenance and Maintenance Supervisor at the exit conference.		in-service education will be provided by the Administrator/designee. The Q.A. Committee will incorporate an ongoing review of emergency planning testing processes to ensure that testing meets regulatory requirements under E039. Any deviation from the regulatory requirements will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the Q.A. Committee.	
K 0000 Bldg. 03	A Life Safety Code Recertification and State	K 0000		

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/10/2024 Facility Number: 000282 Provider Number: 155755 AIM Number: 100287520 At this Life Safety Code survey, Golden Years Homestead 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 one-story facility was determined to be of Type V(111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 111 and had a census of 99 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 10/16/24			
K 0324 SS=E Bldg. 03	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment	K 0324	The gas and electrical power lines of the cooking appliances requiring hood extinguishing systems have been disconnected. Facility will	11/05/2024

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	was designed and installed for 2 of 2 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Director of Maintenance and Maintenance Supervisor from 12:10 p.m. to 2:20 p.m. on 10/10/24, cooking appliances including a gas burner stove and oven with a flat-top grill and deep fryer were located under the hood in 2 of 2 kitchens were not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Director of Maintenance, the facility was not aware an approved method should be provided to ensure		establish an approved method for returning cooking appliances to the proper location in relation to the hood extinguishing equipment under the direction of its kitchen hood extinguishing system servicing agent. The approved method will consist of marking the exact locations on the floor under the hood extinguishing equipment to indicate the placement of the feet of the equipment. The equipment in the two kitchens identified in the LSC survey report will be corrected according to the approved method. The approved method for returning cooking appliances to the proper location in relation to the hood extinguishing equipment will then be applied to all kitchens with hood extinguishing systems throughout Facility. The Director of Maintenance, Maintenance Supervisor and culinary staff will receive in-service training covering the regulatory requirements under K324. The in-service education will be provided by the Administrator/designee. Audits will be conducted three times a week for four weeks and then weekly for three months to ensure upon visual observation that kitchen equipment protected by hood extinguishing systems	

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	that the appliances were returned to an approved design location after maintenance or cleaning. This finding was reviewed with the Director of Maintenance and Maintenance Supervisor at the exit conference. 3.1-19(b)		are properly aligned in relation to the hood extinguishing systems. The Q.A. Committee will review the results of the audits over the duration of the auditing period. Any deviation from the regulatory requirements will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the Q.A. Committee.	
K 0345 SS=C Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm system was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview with the Director of Maintenance and Maintenance Supervisor from 12:10 p.m. to 2:20 p.m. on 10/10/24, the fire control panel indicated time of 15:37 and date of 10/10/24. Based on interview at time of observation the Director of Maintenance and Maintenance Supervisor acknowledged the time on the fire control panel was incorrect. This finding was reviewed with the Director of Maintenance and Maintenance Supervisor at the exit conference.	K 0345	Facility's fire control panel servicing agent will correct the control panel so that the time is accurate. All fire control panels will be inspected by the Maintenance Department to ensure accurate date and time is displayed on the control panel. Any necessary corrections will be made by Facility's fire control panel servicing agent. The Director of Maintenance and Maintenance Supervisor will receive in-service training covering the regulatory requirements under K345. The in-service education will be provided by the Administrator/designee. Routine monitoring of the time display on fire control panels will	11/05/2024

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	3.1-19(b)		be incorporated into the Maintenance Department's preventive maintenance program. The Q.A. Committee will review progress with this plan of correction for a period of six months. Any deviation from the regulatory requirements will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the Q.A. Committee.	
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing 1.) Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and	K 0353	The Facility sprinkler systems inspection process will be changed to ensure that inspections are completed in accordance with regulatory requirements under NFPA 25. Inspection documentation will identify the system, whether it is wet or dry and include adequate valve and gauge inspection documentation. The frequency of the inspection process will be changed so that gauges on dry systems are inspected weekly and include an inspection of valves, gauges and fire department connections. Also, the gauges of wet systems will be inspected monthly but the valves and fire department connections will be inspected weekly. All inspections will include appropriate documentation.	11/05/2024

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	visitors. Findings include: Based on record review and interview with the Director of Maintenance and Maintenance Supervisor from 9:30 a.m. to 12:08 p.m. on 10/10/24, the facility provided a document titled "Sprinkler Riser Tag Inspection Monthly Visual Inspection". Based on observation, the facility has three wet and one dry sprinkler systems. Documentation provided by the facility did not identify what was being inspected or if it was a wet or dry system or if it was a valve or gauge inspection. The documentation was dated and initialed monthly. The Director of Maintenance stated the document provided is how he has been documenting the inspections and no further documentation was available. 2.) Based on observation, and interview; the facility failed to ensure 2 of 2 sprinkler heads behind the 2 of 2 laundry rooms dryers covered with lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading		The two sprinkler heads behind the two laundry rooms will be cleaned with compressed air or a vacuum by maintenance staff. All sprinkler heads throughout Facility will be inspected to ensure they are maintained in accordance with regulatory requirements under K353. Routine, ongoing assessment of sprinkler heads condition will be incorporated into Facility's preventive maintenance program. The Director of Maintenance and Maintenance Supervisor will receive in-service training covering the regulatory requirements under K353. The in-service education will be provided by the Administrator/designee. Monitoring of the Facility sprinkler system inspections and documentation along with preventive maintenance documentation related to sprinkler heads condition/maintenance will be conducted by the Q.A. Committee for a period of six months. Any deviation from the regulatory requirements will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the Q.A. Committee.	

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	(6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect staff in the Laundry room. Findings include: Based on observation and interview with the Director of Maintenance and Maintenance Supervisor from 12:10 p.m. to 2:20 p.m. on 10/10/24, the one sprinkler located behind the laundry room dryers for Communities A and C and the one sprinkler located behind the laundry room dryers for Communities B and D were covered with lint. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned automatic sprinkler was loaded with lint and stated they will need to clean them better. These findings were reviewed with the Director of Maintenance and Maintenance Supervisor at the exit conference. 3.1-19(b)			
K 0761 SS=F Bldg. 03	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen storage room fire door assembly were completed in accordance with LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire	K 0761	An annual inspection and testing of the oxygen storage room door will be completed according to the regulatory requirements under NFPA 80. All fire door assemblies/ fire doors	11/05/2024

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	window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label.		and non-rated doors will be reviewed to confirm that an annual inspection has been completed. Any door found not to have been inspected and tested within the past year will be inspected and tested. The Director of Maintenance and Maintenance Supervisor will receive in-service training covering the regulatory requirements under K761. The in-service education will be provided by the Administrator/designee. The Facility's preventive maintenance program will be updated to ensure that all doors are inspected and tested annually according to the regulatory requirements under NFPA 80. The Q.A. Committee will review the progress with implementing the appropriate preventive maintenance program for a period of six months. Any deviation from the regulatory requirements will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the Q.A. Committee.	

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	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Maintenance and Maintenance Supervisor from 9:30 a.m. to 12:08 p.m. on 10/10/24, the facility provided swinging door assembly inspections; however, the documentation failed to include and inspection of the oxygen storage room. Based on interview at the time of record review and interview, the Director of Maintenance stated an annual inspection was not conducted for the oxygen room fire door assembly in the last year. This finding was reviewed with the Director of Maintenance and Maintenance Supervisor at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens 1.) Based on observation and interview, the facility failed to ensure a multiplug power strip in 1 of 52 resident rooms met UL 1363. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 1 resident who resides in resident room D-17.	K 0920	The multiplug power strip located in resident room D17 has been removed and replaced with one that meets UL 1363. The power strips of unknown UL rating located in the Human Resources office, Admissions office and Accounting office have all been removed and the refrigerators have been plugged directly into the electrical outlet.	11/05/2024

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GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

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	Findings include: Based on observation and interview with the Director of Maintenance and Maintenance Supervisor from 12:10 p.m. to 2:20 p.m. on 10/10/24, resident room D-17 was using a multiplug power strip that lacked a UL 1363 label for resident's personal electrical equipment including a lamp, a phone charger, and a fan. The Director of Maintenance stated he tries to ensure improper power strips are not used but that family members commonly bring them in. 2.) Based on observation and interview with the Director of Maintenance and Maintenance Supervisor from 12:10 p.m. to 2:20 p.m. on 10/10/24, three refrigerators (high power draw equipment) were plugged into and supplied power by a power strip in 3 offices. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 3 staff. Findings include: Based on observation and interview, 1 power strip of unknown UL rating was powering a refrigerator in the human resources office, 1 power strip of unknown UL rating was powering a refrigerator in the admissions office, and 1 power strip of unknown UL rating was powering a refrigerator in the accounting office. Based on interview at the time of observation with the Director of Maintenance stated that education and training with staff will be needed for the proper use of		The entire Facility will be inspected to ensure that multiplug power strips in use meet UL 1363A or UL 60601-1 for patient care vicinities and UL 1362 for non-patient-care-related electronic equipment used in resident rooms, offices and other non-patient vicinities. The primary family member/contact of the residents will be informed of the multiplug power strip requirements. The Leadership Team, Housekeeping and Maintenance department team members will receive in-service training covering the regulatory requirements under K920 regarding the use of multiplug power cords and extension cords. The in-service education will be provided by the Director of Maintenance. The Facility's preventive maintenance program and/or environmental services program will be updated to ensure routine inspection of electrical power equipment, specifically the use of multiplug power strips, meet regulatory requirements under K920. The Q.A. Committee will review the progress with implementation of this program for a period of six months. Any deviation from the regulatory requirements will be addressed through the preparation and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155755	A. BUILDING 03 B. WING	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN YEARS HOMESTEAD	3136 GOEGLEIN RD FORT WAYNE, IN 46815

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	power strips and requirements for high-power-draw equipment. These findings were reviewed with the Director of Maintenance and Maintenance Supervisor at the exit conference. 3.1-19(b)		execution of a performance improvement plan which will be further monitored by the Q.A. Committee.	