STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155806	A. BUILDING -- B. WING	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WABASH	20 JOHN KISSINGER DRIVE WABASH, IN 46992

(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: 02/09/23 Facility Number: 012993 Provider Number: 155806 AIM Number: 201208210 At this Emergency Preparedness survey, Wellbrooke of Wabash 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 70 and had a census of 53 at the time of this survey. Quality Review completed on 02/14/23	E 0000		
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). Survey Date: 02/09/2023 Facility Number: 012993 Provider Number: 155806 AIM Number: 201208210 At this Life Safety Code survey, Wellbrooke of Wabash was found not in compliance with Requirements for Participation in	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
P. Aaron Vogel	Executive Director	02/27/2023

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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	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 rooms. The facility has a capacity of 70 and had a census of 53 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 02/14/23		with exit on February 9th, 2023 Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 22rd, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO	K 0293	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficient practice. Exit sign was	02/22/2023

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	EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. An exit from the Breezeway was marked as NO EXIT but the exit sign on the ceiling in the Breezeway identified it as an exit. This deficient practice could affect 25 residents in the Breezeway area. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) on 02/09/23 at 1:25 p.m., in the Breezeway, the door to the outside courtyard was marked no exit but the exit sign on the ceiling in the Breezeway identified the door as an exit. Based on interview at the time of the observations, the DPO stated the courtyard is not an exit to the public way. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)		replaced to show correct emergency exit direction. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by deficient practice. Campus completed audit of all emergency exit signs and postings to ensure compliance. ED/designee to educate leadership team and DPO on Emergency Exit routs and proper postings. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** As a measure of ongoing compliance, the DPO/designee will audit emergency exit signage monthly x 6 months or immediately upon notification of modification/construction effecting emergency exit pathways. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

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			For quality assurance, the DPO or designee will forward audit results and subsequent corrective action to Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance achieved.	
K 0363 SS=D Bldg. 01	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,			

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	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 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 1 resident room 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 2 residents in room 228. Findings include: Based on observation with the Director of Plant Operations (DPO) on 02/09/23 at 1:05 p.m., the corridor door to resident room 228 did not latch into the frame when tested. Based on interview at the time of observation, the DPO agreed the corridor door would not latch into the door frame. The DPO did repair the door before the end of the survey. The finding was reviewed with the Executive Director and the DPO during the exit conference. 3.1-19(b)	K 0363	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by this deficient practice. Door was adjusted to properly latch into frame before end of survey. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected by this deficient practice. DPO/designee completed campus audit to ensure all applicable corridor doors have no impediment to closing / latching. **what measures will be put into place and what systemic changes will be made to**	02/22/2023

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			ensure that the deficient practice does not recur; Staff to be educated on identifying proper corridor door latching and immediate notification to DPO/designee. As a measure of ongoing compliance, the DPO or designee will audit 10 applicable corridor doors a week x 2 months, then 5 applicable doors a week x 2 months, then 3 applicable doors week x 2 months. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** For quality assurance, the DPO or designee will forward audit results and subsequent corrective action to Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance achieved.	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least two fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies.	K 0761	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficient practice. DPO completed	02/22/2023

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	(See also Section 8.3.) 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 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.		inspection of campus fire doors per policy. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by the deficient practice. DPO educated on annual fire door inspection and documentation. DPO completed inspection of campus fire doors per policy. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** As a measure of ongoing compliance, the DPO or designee will audit documentation of annual fire door inspections to ensure inspection is completed and or scheduled per regulation with proper documentation. The Life Safety Binder & Tels Tasks will be audited monthly x 6 to ensure proper inspection and documentation. If non-compliance noted DPO/designee to immediately notify ED. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	(10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Director of Plant Operations (DPO) on 02/09/23, documentation of a current annual inspection for the fire door assemblies was not available for review. Based on observations with the Director of Plant Operations (DPO) on 02/09/23 at 12:55 p.m. and 1:10 p.m., there were two oxygen rooms with fire-rated doors. Based on interview at the time of records review, the DPO stated the annual fire door inspection was not completed within the last year. This finding was reviewed with the Executive Director and DPO at the exit conference. 3.1-19(b)		**assurance program will be put into place;** For quality assurance, the DPO or designee will forward audit results and subsequent corrective action to Quality Assurance Committee monthly for a minimum of 6 months then randomly thereafter for further recommendations or until 100% compliance achieved.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated			

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	from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 30 residents in two smoke compartments. Findings include: 1. Based on observations with the Director of Plant Operations (DPO) on 02/09/23 at 12:55 p..m. and 1:10 p.m., in 2 of 2 oxygen storage rooms there was no means to separate full cylinders from	K 0923	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficient practice. Oxygen cylinders were properly secured. Signage was added to oxygen storage rooms to designate separate area for full and empty	02/22/2023

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	empty cylinders. Based on interview at the time of observation, the Maintenance Director was not aware that the cylinders needed to be separated. There was not a designated empty cylinder area or empty sign posted in the oxygen storage rooms. 2. Based on obervation with the DPO in the oxygen room on 100 Hall, there were 2 cylinders that were not protected. One was standing upright with no means of securing and the other was leaning against another cylinder that was secured. The findings were reviewed with the Executive Director and DPO during the exit conference. 3.1-19(b)		cylinders. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All Residents have the potential to be affected by the deficient practice**.** DPO educated on Gas Equipment—Cylinder and Container Storage. Staff educated by ED on ensuring cylinders are properly stored and secured and designated areas for empty and full cylinders. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** As a measure of ongoing compliance, the DPO or designee will audit campus oxygen storage rooms for proper storage and signage 5x week x 1 month, then 3x week x 2 months, then weekly x 3 months. If non-compliance noted DPO/designee to immediately notify ED **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

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