STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155679	A. BUILDING -- B. WING	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHLEHEM WOODS NURSING AND REHABILITATION	4430 ELSDALE DR FORT 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 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: 06/20/25 Facility Number: 000260 Provider Number: 155679 AIM Number: 100267820 At this Emergency Preparedness survey, Bethlehem Woods Nursing and Rehabilitation Center 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 88 at the time of this survey. Quality Review completed on 06/25/25	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: 06/20/25 Facility Number: 000260 Provider Number: 155679 AIM Number: 100267820 At this Life Safety Code survey, Bethlehem Woods Nursing and Rehabilitation Center was found not in compliance with Requirements for	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of Credible Allegation. Based on past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher Adams	Executive Director	07/06/2025

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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	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 (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 88 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 06/25/25		revisit on or before July 11, 2025.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 therapy gym doors could resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect 10 residents in the therapy gym. Findings include: Based on observation with the Maintenance Director and the Administrator on 06/20/25 at 12:19 p.m., the corridor door to the therapy gym	K 0363	1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** New hardware was installed on the corridor door to the therapy gym 2. **How other residents having the potential to be affected by the alleged**	07/06/2025

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	had a 2"x4" cutout hole that went through the door. Based on an interview at 12:19 p.m., the Maintenance Director stated the hole was due to where a push bar was removed and still needed to repair the hole. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 1:10 p.m. 3.1-19(b)		**deficient practice will be identified and what corrective action will be taken:** 10 residents have the potential to be affected by the alleged deficient practice. The facility Maintenance Director has toured the facility to ensure that no other holes in doors were identified that met the alleged deficient practice. No other doors were found that had holes. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Maintenance Director has been educated that any time hardware is removed from a door for repair, the new hardware must be installed immediately. 4. 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, Administrator will ensure that a visual assessment is made by the Maintenance Director, or designee, by auditing three (3) corridor doors (1) week for one (1) month and five (5) corridor doors (1) month for the following three (3) months. Results will be reviewed in bi- monthly QA meetings. **By what date the systemic**	

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			changes will be completed: July 11, 2025	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Director on 06/20/25 at 10:22 a.m., the following shifts were missing documentation of a completed fire drill: a) A second shift fire drill for the fourth quarter of 2024. b) A third shift fire drill for the fourth quarter of 2024. Based on an interview at 10:22 a.m., the Maintenance Director stated the fourth quarter fire drills were not conducted due to no Maintenance Director during that time. The findings were reviewed with the Administrator and The Maintenance Director during the exit conference at 1:10 p.m. 3.1-19(b) 3.1-51(c).	K 0712	K712 The facility failed to conduct fire drills on each shift for 1 of 4 quarters. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Director of Maintenance was educated by ED on 7/3/2025 that drills should be held on each shift at least once per quarter and at varying times. 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: Drills will by held monthly at varying times by Director of Maintenance, ED, or designated staff to “ensure staff are familiar with procedures and are aware that drills are part of established routine.” What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Monthly log to by kept by Director of Maintenance with varying times and dates noted, implemented by	07/06/2025

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			7/6/2025. 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: Director of Maintenance, ED, or designated staff to monitor in QA and report any findings for 6 months. ED will conduct monthly audit x 6 months to ensure all fire drills are completed. By what date the systemic changes will be completed: July 11, 2025	