STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155694	A. BUILDING -- B. WING	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETZ NURSING HOME	116 BETZ RD AUBURN, IN 46706

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/23/22 Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860 At this Emergency Preparedness survey, Betz Nursing Home 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 108 and had a census of 75 at the time of this survey. Quality Review completed on 08/24/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/23/22 Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860 At this Life Safety Code survey, Betz Nursing Home was found not in compliance with Requirements for Participation in	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 of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance. Facility respectfully requests desk review in lieu of on-site revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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 (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 108 and had a census of 75 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 08/24/22			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 5 of 5 battery backup emergency lights were tested annually for 90 minutes. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having	K 0291	**K 291 Emergency Lighting** It is the practice of this provider to perform annual emergency lighting testing in accordance with State and Federal regulations. **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director completed the 90-minute annual emergency	08/29/2022

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	jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 08/23/22 at 9:57 a.m., annual testing for the battery backup emergency lights were past due. The Battery-Operated Emergency Light Test Log indicated the last annual 90-minute testing for the five battery backup emergency lights was conducted on 04/29/21. Based on an interview at the time of records review, the Maintenance Director stated the annual 90-minute testing for the five battery backup emergency lights have not been conducted in the past 12 months and were past due. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		lighting testing on 8/29/22. TELS test log attached. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Maintenance Director and Executive Director completed an audit on all emergency lighting testing. All required testing is current. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and ED to review TELS checklist items monthly to ensure compliance with testing requirements. Maintenance Director in-service completed by Executive Director. **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?** ED/Maintenance Director/Designee to complete QAPI tool for Life Safety weekly x 4, monthly x 6. If 95% is not achieved an action plan will be developed. Results will be reviewed during monthly QAPI meeting.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors			

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	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 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.			

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	Based on observation and interview, the facility failed to ensure 1 of 1 Marketing office double corridor doors were provided with positive latching hardware with means suitable for keeping the door closed. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 08/23/22 at 1:43 p.m., the left door leaf of the double set of corridor doors to the Marketing office had a manual latching device. Based on interview at the time of observation, the Maintenance Director stated the set of corridor doors could only be manually latched into the frame. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0363	It is the practice of this provider to ensure the corridor doors meet State and Federal requirements. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Facility had a hard wired smoke detector installed in the Marketing office on 9/1/22 to compensate for the manual latching device. Before and after photo's attached. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Full facility audit completed by Maintenance Director and Executive director. No other corridor doors identified as having a manual latching device. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director and Executive Director to review and approve the installation of any new doors in the facility to ensure that they meet the latching requirements. Maintenance Director in-service completed by Executive Director. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance**	09/01/2022

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			program will be put into place? ED/Maintenance Director/Designee to complete QAPI tool for Life Safety weekly x 4, monthly x 6. If 95% is not achieved an action plan will be developed. Results will be reviewed during monthly QAPI meeting.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure penetrations through 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires,	K 0372	It is the practice of this provider to ensure smoke barrier walls are free from unsealed penetrations. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Maintenance Director applied 3M Fire Barrier Sealant CP25WB+ to the unsealed penetrations that were identified in the smoke barrier walls by room 500 and by	08/26/2022

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	and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could 40 residents in three smoke compartments. Findings include: Based on observation with the Maintenance Director on 08/23/22 at 1:45 p.m., unsealed ½ inch gaps around pentrations of a pipe and wires above the drop ceiling of the smoke barrier walls by room 500 and the Business office were noted. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed penetrations in the two smoke barriers. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		the Business Office. Before and after photo's attached. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** Maintenance Director performed audit of all smoke barrier walls and no other unsealed penetrations were identified. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Maintenance Director or designee to visually inspect contractor work prior upon completion. Maintenance Director in-service completed by Executive Director. **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?** ED/Maintenance Director/Designee to complete QAPI tool for Life Safety weekly x 4, monthly x 6. If 95% is not achieved an action plan will be developed. Results will be reviewed during monthly QAPI meeting.	