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	07/25/2024

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: 07/25/24 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 85 at the time of this survey. Quality Review completed on 07/29/24	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: 07/25/24 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	08/12/2024

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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	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 85 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 07/29/24		revisit on or before August 16, 2024.	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 20 portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1	K 0355	It is the practice of this provider to ensure that all portable fire extinguishers are inspected annually.	08/12/2024

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	year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could 2 residents in the Beauty Shop. Findings include: Based on observation with the Maintenance Director on 07/25/24 at 11:13 a.m., the tag on the fire extinguisher in the Beauty Shop had an annual inspection date of July 2022 while all other fire extinguishers in the building had an inspection date of July 2024. Based on an interview at the time of observation, the Maintenance Director stated it is most likely the extinguisher was missed during the annual inspection. The finding was reviewed with the Social Service Coordinator and Maintenance Director during the exit conference. 3.1-19(b)		1. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The fire extinguisher found in the beauty shop was immediately removed from service on 7/25/24. 2. **How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** Two residents in the beauty shop had the potential to be affected by the alleged deficient practice. All portable fire extinguishers have been inspected within the last 12 months. 3. **What measures will be put into place and what systemic changes**	

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			will be made to ensure that the deficient practice does not recur: All portable fire extinguishers have been identified and logged into TELS Maintenance program. Administrator and Maintenance Director to review and round on portable fire extinguishers annually to ensure all have been inspected as required. 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, the Administrator will review the TELs program with Maintenance Director and round the facility portable fire extinguishers to ensure compliance. Results of the review will be reviewed at the bi-monthly QAPI meeting overseen by the Administrator following the annual inspection. **By what date the systemic changes**	

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			will be completed: August 12, 2024	
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 observations, records review, and interview, the facility failed to ensure 1 of 5 smoke barrier walls were constructed to requirements according to the authority having jurisdiction (AHJ). LSC 8.2.3.1 states the fire resistance of structural elements and building assemblies shall be determined in accordance with test procedure set forth in ASTM E 119, Standard Test Methods for Fire Tests of Building Construction and Materials, or ANSI/UL 263, Standard for Fire Tests of Building Construction and Materials; other approved test methods; or analytical methods approved by the AHJ. The AHJ requires penetrations in smoke barriers to be sealed with a firestop system or device tested in accordance with ASTM E 814. This deficient practice could affect 50 residents in two smoke compartments.	K 0372	It is the practice of this provider to ensure that all penetrations/gaps are sealed with a compound that meets ASTM 814 requirements. 1. **What corrective action will** **be accomplished for those** **residents found to have** **been affected by the deficient practice:** The gaps in the smoke wall located on the D-wing ceiling	08/12/2024

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	Findings include: Based on observation with the Maintenance Director on 07/25/24 at 12:33 p.m., above the ceiling tiles by the dining room, the D-wing smoke wall had four conduits that were sealed with drywall joint compound. Based on records review at 12:35 p.m., there was no documentation to show the compound meets ASTM 814. Based on interview at the time of observation, the Maintenance Director agreed joint compound was used to seal the gaps in a smoke wall. The finding was reviewed with the Social Service Coordinator and Maintenance Director during the exit conference. 3.1-19(b)		were sealed with fire caulk that meets ASTM 814 requirements. 2. **How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** All 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 gaps were identified that did not meet the alleged deficient practice. No other locations were found that had been sealed with drywall joint compound. 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**:	

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			Maintenance Director has been educated that drywall joint compound is not permitted to be used to seal any gaps/penetrations. 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) smoke/attic barrier locations every one (1) week for one (1) month and five (5) smoke/attic barrier locations every one (1) month for the following three (3) months. Results will be reviewed in bi-monthly QA meetings. **By what date the systemic changes** **will be completed:** August 12, 2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas			

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	Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical boxes was securely fastened in place and 1of 4 outlets in room106 contained a cover plate. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. 1.) Article 406.5 states Receptacles shall be mounted in boxes or assemblies designed for the purpose, and such boxes or assemblies shall be securely fastened in place unless otherwise permitted elsewhere in this Code. 2.) Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 4 residents in two resident rooms. Findings include: Based on observation with the Maintenance Director on 07/25/24 between 12:30 p.m. and 1:00 p.m., 1.) In resident room 106 there was an electrical box hanging from the wall by the TV exposing wires. 2.) In room 113 there was an electrical outlet by the window missing the cover plate exposing the electric terminals. Based on an interview at the time of observation, the Maintenance Director agreed the electrical box in 206 was not fastened securely and the outlet in room 113 was missing the cover plate.	K 0511	1. What corrective action(s) will be accomplished for the residents found to be affected by the deficient practice? On 7/25/2024,the electrical box in room 106 was securely fastened to the wall and the electrical outlet in room 113 was covered with a cover plate. 2. How will you identify other residents that have the potential to be affected by the same deficient practice and what corrective action will be taken? 4 residents who reside in the resident rooms had the potential to be affected by the alleged deficient practice. 3, What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Audit to be completed on remaining receptacles by 8/16/24 by Maintenance Director/Designee.	08/16/2024

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	The finding was reviewed with the Social Service Coordinator and Maintenance Director during the exit conference. 3.1-19(b)		4. 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? The Maintenance Director/designee will utilize the CQI audit tool titled Receptacle Validation-once throughout the facility x 1, then annually. With results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold for 90% is not achieved an action plan will be developed to ensure compliance.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere	K 0522	1. What corrective action(s) will be accomplished for the residents found to be affected by the deficient practice?	08/12/2024

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	rich with carbon monoxide which could cause physical problems for staff in the laundry room. Findings include: Based on observation with the Maintenance Director on 07/25/24 at 11:23 a.m., the laundry room had fuel-fired dryers with a fresh air intake that was 75 percent covered with lint and dirt. This condition did not allow for fresh air to completely enter the room. Based on an interview at the time of observation, the Maintenance Director stated the intake was covered with lint and would need to be cleaned. The finding was reviewed with the Social Service Coordinator and Maintenance Director during the exit conference. 3.1-19(b)		On 7/25/24, the fresh air intake located in the laundry room was cleaned and free from lint. 2. How will you identify other residents that have the potential to be affected by the same deficient practice and what corrective action will be taken? Staff who work in the laundry room had the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? A daily cleaning checklist was created for the fresh air intake to be cleaned daily and monitored by EVS Supervisor. 4. 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? The EVS Supervisor/designee to audit the daily cleaning checklist to ensure completion weekly. ED and/or Maintenance Director/Designee will monitor the fresh air intake weekly to ensure 100% compliance.	
K 0920 SS=D	NFPA 101 Electrical Equipment - Power Cords and			

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Bldg. 01	Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects two residents. Findings include: Based on observation with the Maintenance Director on 07/25/24 at 12:30 p.m., by resident bed #2 in room 117, there was a power-strip within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on an interview at the time of observation, the Maintenance Director	K 0920	1. The corrective action taken for the resident found to have been affected by the deficient practice: Immediately: The surge protector was removed from resident room 117. 2. The corrective action for those residents having the potential to be affected by the same deficient practice: On 7/25/24, all rooms were	08/12/2024

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	agreed there was a power-strip in use in resident care area and did not meet 1363A or 60601-1. The finding was reviewed with the Social Service Coordinator and Maintenance Director during the exit conference. 3.1-19(b)		checked to ensure that there were no further use of non-hospital grade surge protectors, power strips and multipurpose adapters. 3. The measures put into place and a systemic change made to ensure the deficient practice not reoccur: Maintenance Director was given 1:1 education on 8/8/24 regarding the use of surge protectors, multiplug adapters, and power strips. 4. To ensure the deficient practice does not reoccur, the monitoring system established is to: Administrator/ Designee will monitor 3X per week alternate areas in the building to ensure that devices are used as per policy for 4 weeks. Then 2X per week for 3 months. Any issued will be addressed immediately by Administrator.	