STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155349	A. BUILDING -- B. WING	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE HOME	1900 RANDALLIA DR FORT WAYNE, IN 46805

(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: 03/24/25 Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960 At this Emergency Preparedness survey, Saint Anne Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 166 certified beds. At the time of the survey, the census was 114. Quality Review conducted on 03/26/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/24/25 Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960 At this LSC survey, Saint Anne Home was found not in compliance with Requirements for	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elaine Wilson	COO	04/21/2025

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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	155349	A. BUILDING 01 B. WING	03/24/2025

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SAINT ANNE HOME	1900 RANDALLIA DR FORT WAYNE, IN 46805

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	Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101, LSC and 410 IAC16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. The facility consists of two attached buildings: Bldg. #1 a three-story building Type II (222) and Bldg. #2 Type V (111). Building #1 is a three story building with basement, is fully sprinklered, and is Type II (222) construction. 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. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility has a capacity of 166 and had a census of 114 at the time of this survey. Quality Review conducted on 03/26/25			
K 0225 SS=F Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Based on observation and interview, the facility failed to ensure 2 of 2 exit stairways had at least 50 percent of the exits lead directly to the outside. LSC 7.7.1 states exits shall terminate directly, at a public way or at an exterior exit discharge, unless otherwise provided in 7.7.1.2 through 7.7.1.4. LSC 7.7.2 Exits shall be permitted to discharge through interior building areas, provided that all of the following are met: (1) not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall discharge through areas on any level of	K 0225	K-225 **FSES now uploaded what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The building does not have a stairwell directly to the outside of the building. Saint Anne's annually received a report from RTM consultants stating "…the facility will be considered to be in	04/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155349	A. BUILDING 01 B. WING	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE HOME	1900 RANDALLIA DR FORT WAYNE, IN 46805

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	discharge. This deficient practice could affect staff and all residents in Building One. Findings include: Based on observation with the Facilities Director on 03/24/25 at 11:30 a.m. and 12:30 p.m., the southwest stairs and northeast stairs, which total all stairway exits from the second and third floors, discharged onto the first floor and not directly to the exterior of the building. Based on interview at 11:30 a.m. and 12:30 p.m., the Facilities Director stated all stairwells discharged onto the first floor and not directly outside. This finding was reviewed with the Facilities Director during the exit conference at 2:00 p.m. 3.1-19(b)		equivalent compliance with the provisions of NFPA 101-2012 upon completion of the plan for Improvement completed by the facility" 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 residing on 2nd and 3rd floor have the potential to be affected. The building does not have a stairwell directly to the outside of the building. Saint Anne's annually received a report from RTM consultants stating "…the facility will be considered to be in equivalent compliance with the provisions of NFPA 101-2012 upon completion of the plan for Improvement completed by the facility" what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Saint Anne's will contract with RTM consultants in 2024 for a building review. It would be an unreasonable burden displacing residents with an astronomical financial burden to renovate the building to have a stairwell with a direct exit of the building. how the corrective action(s)	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Due to the nature of the citation, the ability to monitor the stairwells burdensome reconstruction is constant in nature. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 2 stairway exits contained exit signs that are displayed in accordance with LSC 7.10 with continuous illumination. This deficient practice could affect 30 residents in the Lavendel hall. Findings include: Based on an observation with the Facilities Director on 03/24/25 at 1:02 p.m., the main dining room exit door contained an exit sign without continuous illumination. The sign was not	K 0293	K293 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; An exit sign was added that is self illuminating to ensure during power outage, the exit sign will be continuously luminated how other residents having the potential to be affected by the	04/07/2025

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	self-illuminating, and it was unknown if the light by the door was powered by the generator. Based on an interview at 1:02 p.m., the Facilities Director stated it is unknown if the exit sign was under continuous illumination. This finding was reviewed with the Facilities Director during the exit conference at 2:00 p.m. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken; All residents with vision impairments have the potential to be affected what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A self illuminating exit sign was placed to ensure there is a constantly illuminated exit sign available to assist residents in exiting. 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; and The new exit sign will be added to the current monthly exit sign audits. The monthly audit will be shared with the internal monthly QA meeting until one year of deficiency free audits. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division	

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			needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. April 7, 2025	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure 1 of 2 stairway exits contained exit signs that are displayed in accordance with LSC 7.10 with continuous illumination. This deficient practice could affect 30 residents in the Lavendel hall. Findings include: Based on observation with the Facilities Director on 03/24/25 at 1:00 p.m., the kitchen was provided with a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview at 1:01 p.m., the Cook was asked how to activate the hood suppression system if there was a grease fire underneath the hood. The Cook did not know where the pull station to activate the suppression system was located and stated she was not shown where the pull was located. The Maintenance Director acknowledged the Cooks response and stated staff will need to be trained on the proper procedures for extinguishing a grease fire on the cooking equipment. This finding was reviewed with the Facilities Director during the exit conference at 2:00 p.m.	K 0324	K324 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Dining staff all educated on location of hood fire suppression activation switch. 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 what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Training completed with all dining staff. The education of location of hood fire suppression activation switch will be added to new team member orientation.	04/07/2025

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			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; and The education of new team members will be added to the new orientation check lists. The new orientation check lists will be audited monthly by HR and reviewed at the internal monthly QA meeting until one year of no deficiencies. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. April 7, 2025	
K 0000 Bldg. 04	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/24/25	K 0000		

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	Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960 At this LSC survey, Saint Anne Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101, LSC and 410 IAC16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. The facility consists of two attached buildings: Bldg. #1 a three-story building Type II (222) and Bldg. #4 Type V (111). Building #4 is a one-story building consisting of the main entrance, dining, the chapel, and rehabilitation unit with a physical therapy gym is fully sprinklered of Type V (111) construction. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors and hard-wired smoke detectors in the Rehabilitation hall resident rooms. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility has a capacity of 166 and had a census of 114 at the time of this survey. Quality Review conducted on 03/26/25			