PRINTED: 04/23/2025 FORM APPROVED

04/21/2025

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
		155349	B. WING		03/24/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 03/24 Facility Number: 00 Provider Number: 1 1002 At this Emergency I Anne Home was for Emergency Prepare Medicare and Mediand Suppliers, 42 C The facility has 166 the survey, the cens	2/25 20240 55349 274960 Preparedness survey, Saint and in compliance with dness Requirements for caid Participating Providers FR 483.73. The certified beds. At the time of us was 114.	E 0000			
K 0000	Quality Review con	ducted on 03/26/25				
Bldg. 01	Licensure Survey w	(LSC) Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0000			
	Survey Date: 03/24	1/25				
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	55349				
	-	yith Requirements for				
LABORATOR	ABORATORY 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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Elaine Wilson

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155349	B. WING 03/24/2025				
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME			STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Subpart 483.90(a), ledition of National (NFPA) 101, LSC a	dicare/Medicaid, 42 CFR Life Safety from Fire, the 2012 Fire Protection Association and 410 IAC16.2. The building Chapter 19 Existing Health					
	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.						
K 0225 SS=F Bldg. 01	NFPA 101	nducted on 03/26/25 sokeproof Enclosures					
_	failed to ensure 2 of percent of the exits LSC 7.7.1 states exipublic way or at an otherwise provided 7.7.2 Exits shall be interior building are following are met: (the required number percent of the required states)	on and interview, the facility of 2 exit stairways had at least 50 lead directly to the outside. its shall terminate directly, at a exterior exit discharge, unless in 7.7.1.2 through 7.7.1.4. LSC permitted to discharge through eas, provided that all of the (1) not more than 50 percent of or of exits, and not more than 50 red egress capacity, shall reas on any level of	K 0225	K-225 **FSES now uploaded what corrective action(s) be accomplished for those residents found to have been affected by the deficient practi The building does not ha stairwell directly to the outside the building. Saint Anne's ann received a report from RTM consultants stating "the faci will be considered to be in	ice; ave a e of ually		

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		X1) PROVIDER/SUPPLIER/CLIA	` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		<u>01</u> COMPLE		
		155349	B. WING 03/24/2025			2025	
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIE				1900 R	ADDRESS, CITY, STATE, ZIP COD ANDALLIA DR WAYNE, IN 46805		(V5)
(X4) ID PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION
TAG	discharge. This de staff and all resider Findings include: Based on observation 03/24/25 at 11:3 southwest stairs an all stairway exits fi discharged onto the the exterior of the 11:30 a.m. and 12: stated all stairwells and not directly out.	ficient practice could affect ats in Building One. In the Facilities Director and a.m. and 12:30 p.m., the donortheast stairs, which total from the second and third floors, are first floor and not directly to building. Based on interview at 30 p.m., the Facilities Director adischarged onto the first floor tside. Eviewed with the Facilities are exit conference at 2:00 p.m.		TAG	equivalent compliance with the provisions of NFPA 101-2012 completion of the plan for Improvement completed by the facility" how other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; All residents residing on and 3rd floor have the potential be affected. The building does have a stairwell directly to the outside of the building. Saint Anne's annually received a refrom RTM consultants stating "the facility will be considered be in equivalent compliance with provisions of NFPA 101-20 upon completion of the plan for Improvement completed by the facility." what measures will be pinto place and what systemic changes will be made to ensurth the deficient practice does recur; Saint Anne's will contract with RTM consultants in 2024 building review. It would be an unreasonable burden displacing residents with an astronomical financial burden to renovate the building to have a stairwell with direct exit of the building.	upon e ing the 2 2nd al to s not port ed to vith 012 or e ut re s not ct for a n ng I ne ch a	DATE

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STATEMENT OF DEFICIENCIES X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155349	B. WI	NG		03/24/	/2025
NAME OF I	PROVIDER OR SUPPLIE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
		X			ANDALLIA DR		
SAINT A	NNE HOME			FORT \	WAYNE, IN 46805		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	+	TAG			DATE
					will be monitored to ensure the deficient practice will not recu		
					i.e., what quality assurance	Ι,	
					program will be put into place		
					program viii be par inte piace		
					Due to the nature of the		
					citation, the ability to monitor	the	
					stairwells burdensome		
					reconstruction is constant in		
					nature.		
					- by what date the system	nio.	
					changes for each deficiency v		
					be completed. After submitting		
					acceptable Plan of Correction	_	
					is determined that the correcti		
					will not be completed by the d	ate	
					previously submitted, the Divi	sion	
					needs to be contacted as soo		
					possible. The facility will need	d to	
					submit an amended plan of		
					correction with the updated pl	an of	
					correction date.		
K 0293	NFPA 101						
SS=E	Exit Signage						
Bldg. 01							
		on and interview, the facility	K 0	293	<u>K293</u>		04/07/2025
		f 2 stairway exits contained exit					
	-	ayed in accordance with LSC			what corrective action(s) will	
		us illumination. This deficient			be accomplished for those		
	_	et 30 residents in the Lavendel			residents found to have been		
	hall.				affected by the deficient pract		
	Findings include:				An exit sign was added is self illuminating to ensure d		
	i manigo meiude.				power outage, the exit sign wi	-	
	Based on an observ	vation with the Facilities			continuously luminated	11 00	
		25 at 1:02 p.m., the main dining			Tanadasi, idiinidaa		
		tained an exit sign without			how other residents hav	ing	
		ation. The sign was not			the potential to be affected by	_	

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	OF CORRECTION	IDENTIFICATION NUMBER 155349	A. BUILDING B. WING	<u>01</u>	COMPLETED 03/24/2025			
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME			1900 R	STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	by the door was pov on an interview at 1 stated it is unknown continuous illumina	d it was unknown if the light wered by the generator. Based :02 p.m., the Facilities Director if the exit sign was under tion.		same deficient practice will be identified and what corrective action(s) will be taken; All residents with vision impairments have the potential be affected				
	Director during the 3.1-19(b)	exit conference at 2:00 p.m.		what measures will be p into place and what systemic changes will be made to ensu that the deficient practice doe recur; A self illuminating exit si	re s not			
				was placed to ensure there is constantly illuminated exit signavailable to assist residents in exiting.	a n			
				how the corrective action will be monitored to ensure the deficient practice will not recurite., what quality assurance program will be put into place. The new exit sign will be added to the current monthly sign audits. The monthly audit be shared with the internal monthly QA meeting until one year of deficiency free audits.	e r, ; and exit t will			
				by what date the system changes for each deficiency was be completed. After submitting acceptable Plan of Correction is determined that the correction will not be completed by the depreviously submitted, the Divisional previously submitted.	vill g an , if it on ate			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155349	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/24/2025
	PROVIDER OR SUPPLIER		1900 F	ADDRESS, CITY, STATE, ZIP COD RANDALLIA DR WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				needs to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plateorrection date. April 7, 2025	d to
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities				
	failed to ensure 1 of signs that are displa 7.10 with continuou practice could affect hall. Findings include: Based on observation 03/24/25 at 1:00 with a UL 300 hood extinguisher with pointerview at 1:01 p. activate the hood sure a grease fire undern not know where the suppression system was not shown whe Maintenance Direct response and stated on the proper proce grease fire on the countries.	on and interview, the facility 2 stairway exits contained exit yed in accordance with LSC is illumination. This deficient it 30 residents in the Lavendel on with the Facilities Director p.m., the kitchen was provided it system and a K-class fire osted instructions. Based on m., the Cook was asked how to ppression system if there was eath the hood. The Cook did pull station to activate the was located and stated she re the pull was located. The or acknowledged the Cooks staff will need to be trained dures for extinguishing a poking equipment. viewed with the Facilities exit conference at 2:00 p.m.	K 0324	what corrective action(s) be accomplished for those residents found to have been affected by the deficient practicular Dining staff all educated location of hood fire suppressifuctivation switch. how other residents have the potential to be affected by 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 p into place and what systemic changes will be made to ensuth that the deficient practice does recur; Training completed with dining staff. The education of location of hood fire suppressifuction switch will be added new team member orientation	ice; on on ing the ut re s not all

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	OF CORRECTION	IDENTIFICATION NUMBER 155349	A. BUILDING B. WING	01	COMPLETED 03/24/2025
	ROVIDER OR SUPPLIER		1900 R	ADDRESS, CITY, STATE, ZIP COD ANDALLIA DR WAYNE, IN 46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				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;	e C,
				The education of new te members will be added to the orientation check lists. The ne orientation check lists will be audited monthly by HR and reviewed at the internal month QA meeting until one year of r deficiencies.	new w
				by what date the system changes for each deficiency where completed. After submittin acceptable Plan of Correction is determined that the correctifuil not be completed by the dipreviously submitted, the Division needs to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plat correction date.	vill g an , if it on ate sion n as I to
				April 7, 2025	
K 0000					
Bldg. 04	Licensure Survey w	(LSC) Recertification and State as conducted by the Indiana th in accordance with 42 CFR	K 0000		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>04</u>		COMPLETED		
		155349	B. WING		03/24/2025		
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME			1900 R	STREET ADDRESS, CITY, STATE, ZIP COD 1900 RANDALLIA DR FORT WAYNE, IN 46805			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Facility Number: (Provider Number: 100 At this LSC survey not in compliance Participation in Management of National (NFPA) 101, LSC was surveyed with Care Occupancies. The facility consist Bldg. #1 a three-st Bldg. #4 Type V (Building #4 is a or the main entrance, rehabilitation unit fully sprinklered of The facility has a factor of the detectors in the concorridors and hard Rehabilitation hall the residents have sprinklered. All an were sprinklered. The and had a census of the surveyed to the surveyed	274960 274960 27, Saint Anne Home was found with Requirements for edicare/Medicaid, 42 CFR Life Safety from Fire, the 2012 21 Fire Protection Association and 410 IAC16.2. The building Chapter 19 Existing Health ts of two attached buildings: ory building Type II (222) and					

Event ID: $YDMZ21 \quad \ \ {\rm Facility} \ {\rm ID} {:} \quad \ 000240$ If continuation sheet Page 8 of 8