

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155475	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2022
NAME OF PROVIDER OR SUPPLIER TOWNE HOUSE RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 ST JOE CENTER RD FORT WAYNE, IN 46825	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/07/22 Facility Number: 000541 Provider Number: 155475 AIM Number: N/A At this Emergency Preparedness survey, Towne House Retirement Community 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 32 Medicare only beds and had a census of 4 at the time of this survey.	E 000		
K 000	Quality Review completed on 07/13/22 INITIAL COMMENTS 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: 07/07/22 Facility Number: 000541 Provider Number: 155475 AIM Number: N/A At this Life Safety Code survey, Towne House Retirement Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a),	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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K 000	Continued From page 1 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 with a walkout lower level below the southeast wing was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Battery operated smoke detectors were installed in the resident rooms. The facility has a capacity of 32 Medicare beds and had a census of 4 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached barn providing facility services including storage of mowers, maintenance equipment and two buses that was not sprinklered.	K 000			
K 131 SS=F	Quality Review completed on 07/13/22 Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8.	K 131			

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K 131	<p>Continued From page 2</p> <ul style="list-style-type: none"> o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 2 of 3 fire barrier walls that separated Medicare wing from private pay was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect all residents in the Medicare wing.</p> <p>Findings include:</p> <p>Based on observation with the Assistant</p>	K 131			

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K 131	Continued From page 3 Executive Director and Maintenance Tech on 07/07/22 at 1:00 p.m., above the drop ceiling of the separation fire barrier by room 305 had three holes in the wall measuring up to 20 square inches. Also, above the drop ceiling of the separation fire barrier by the kitchen had a 2-inch unsealed gap around a pipe. Based on interview at the time of observation, the Maintenance Tech agreed the separation fire barriers had unsealed holes through the walls. The finding was reviewed with the Assistant Executive Director, Director of Environmental, and Maintenance Tech during the exit conference.	K 131			
K 222 SS=F	3.1-19(b) Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS	K 222			

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K 222	<p>Continued From page 4</p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p>	K 222			

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K 222	<p>Continued From page 5</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to maintain the means of egress through 3 of 3 exits with access-controlled doors. LSC 19.2.2.2.4(3) states access-controlled egress doors complying with 7.2.1.6 shall be permitted. As a requirement for access-controlled doors LSC 7.2.1.6.2(3)(c) states when operated, the manual release device shall result in the interruption of power to the lock and the lock shall remain unlocked for not less than 30 seconds. This deficient practice could affect all residents in the Medicare Wing.</p> <p>Findings include:</p> <p>Based on observation with the Assistant Executive Director, Director of Environmental, and Maintenance Tech on 07/07/22 between 10:45 a.m. and 1:00 p.m., the 3 exit doors for the Medicare Wing were locked with a magnetic lock that was deactivated by entering a code into the keypad located adjacent to the door. When the code was entered, the door only unlocked for approximately four seconds, not allowing enough time for a person to open the door. Based on interview at the time of observation, the Maintenance Tech stated the exit door would only unlock for about three to four seconds after the code was entered.</p> <p>The finding was reviewed with the Assistant Executive Director, Director of Environmental, and Maintenance Tech during the exit conference.</p> <p>3.1-19(b)</p>	K 222			

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K 524 SS=F	<p>HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101</p> <p>Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview; the facility failed to ensure 2 of 2 direct-vent fireplaces was protected according to LSC 19.5.2.3(2). Direct-vent gas fireplaces, as defined in NFPA 54, National Fuel Gas Code, shall be permitted inside of smoke compartments containing patient sleeping areas, provided that all of the following criteria are met: (a) All such devices shall be installed, maintained, and used in accordance with 9.2.2. (b) No such device shall be located inside of a patient sleeping room. (c) The smoke compartment in which the direct-vent gas fireplace is located shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 9.7.1.1(1) with listed quick response or listed residential sprinklers. (d) The direct-vent fireplace shall include a sealed glass front with a wire mesh panel or screen. (e) The controls for the direct-vent gas fireplace shall be locked or located in a restricted location. (f) Electrically supervised carbon monoxide detection in accordance with Section 9.8 shall be provided in the room where the fireplace is</p>	K 524			

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K 524	Continued From page 7 located. This deficient practice could affect all Medicare residents. Findings include: Based on an observation during a tour of the facility with the Assistant Executive Director, and Maintenance Tech on 07/07/22 at 12:37 p.m., in the lobby and in the Great Room there were direct vent fireplaces that were not protected by electrically supervised carbon monoxide detection. Also, the lobby fireplace did not have a sealed glass front with a wire mesh panel or screen. Based on interview at the time of observation, the Assistant Executive Director, and Maintenance Tech agreed there were not carbon monoxide detectors in the lobby and the Great Room, and did not have no sealed glass front with a wire mesh panel or screen for the fire place in the lobby. The finding was reviewed with the Assistant Executive Director, Director of Environmental, and Maintenance Tech during the exit conference.	K 524			
K 781 SS=F	3.1-19(b) Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	K 781			

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K 781	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in health care occupancies. This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Assistant Executive Director, Director of Environmental, and Maintenance Tech on 07/07/22 12:27 p.m., a portable space heater was in the therapy gym. Based on interview at the time of the observations, the Maintenance Director agreed a space heater was in a resident care area. The finding was reviewed with the Assistant Executive Director, Director of Environmental, and Maintenance Tech during the exit conference.	K 781			
K 918 SS=F	3.1-19(b) Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918			

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K 918	<p>Continued From page 9</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generators contained a battery backup light. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Assistant Executive Director, and Maintenance Tech on 07/07/22 at 11:15 a.m.,</p>	K 918			

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K 918	Continued From page 10 there was no emergency battery powered light at the generator. Based on an interview at the time of observation, the Maintenance Tech agreed there was no battery powered light at the generator. The finding was reviewed with the Assistant Executive Director, Director of Environmental, and Maintenance Tech during the exit conference. 3.1-19(b)	K 918		