STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155475	A. BUILDING -- B. WING	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOWNE HOUSE RETIREMENT COMMUNITY	2209 ST JOE CENTER RD FORT WAYNE, IN 46825

(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: 07/07/22 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. Quality Review completed on 07/13/22	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: 07/07/22 Facility Number: 000541 Provider Number: 155475 AIM Number: N/A At this Life Safety Code survey, Towne House Retirement Community was found not in	K 0000		

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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	compliance with Requirements for 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 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. Quality Review completed on 07/13/22			
K 0131 SS=F Bldg. 01	NFPA 101 Multiple Occupancies 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.			

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	o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 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 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. Findings include: Based on observation with the Assistant 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.	K 0131	**K131: Multiple Occupancies-Sections of Health Care Facilities** **Corrective Action to be accomplished:** Unsealed gaps around pipes and holes were sealed closed. This was result of contractor providing a repair that left without properly sealing the area shut when the work was complete. **How other residents having potential to be affected will be identified and what corrective action is taken:** The area affected was identified being East wing where no residents reside, and the first section of south wing up to the fire doors where six residents resided. The area has been properly sealed off and therefore no other residents are affected. **Measures that will be put into place and what systemic changes to be made:** A member of the maintenance team shall do a final inspection with the contractor to authorize accurate completion of any fire wall penetrations being provided upon	07/18/2022

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	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. 3.1-19(b)		completion. The purpose of this follow up is to ensure that the work was done appropriately, and proper measures are taken to follow fire safety code. **How will it be monitored to ensure no reoccurrence:** The documented follow up on all fire wall work shall be reviewed at QAPI meetings quarterly for at least one year and evaluated to continue past one year if needed. **Date the systemic change will be completed:** The corrective action has been completed effective July 18, 2022.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors 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			

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	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. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS 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			

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	system. 18.2.2.2.4, 19.2.2.2.4 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. Findings include: 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. The finding was reviewed with the Assistant Executive Director, Director of Environmental, and Maintenance Tech during the exit conference. 3.1-19(b)	K 0222	**K222: Egress Doors** **Corrective Action to be accomplished:** The Electric locking keypad system control shall be adjusted to meet the regulation of remaining unlocked for not less than 30 seconds for 3 of 3 exit doors. **How other residents having potential to be affected will be identified and what corrective action is taken:** The three exits surround the areas located on the north wing where there are 10 residents residing, and the west wing where there are 13 residents residing. Corrective action will be to adjust the locking control to meet the regulatory requirements of remaining unlocked for not less than 30 seconds for all identified exits. **Measures that will be put into place and what systemic changes to be made:** A member of the maintenance team checks the exits for appropriate functioning and meeting of regulatory guidance daily and records results of findings on the tracking log. **How will it be monitored to ensure no reoccurrence:** The documented tracking log used to check for appropriate functioning shall be measured in the QAPI audits and reviewed quarterly. This shall continue for at least one year	07/20/2022

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			and evaluated to continue past one year if needed. **Date the systemic change will be completed:** The corrective action has been completed effective July 20, 2022.	
K 0524 SS=F Bldg. 01	NFPA 101 HVAC - Direct-Vent Gas Fireplaces 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 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 located.	K 0524	**K524: HVAC Direct Vent Gas Fireplaces** **Corrective Action to be accomplished:** Each fire place will be equipped with the sealed glass front and wire mesh screen per regulatory guidelines. As well, electrically supervised carbon monoxide detectors shall be hard wired to work along with our fire system as per regulatory guidelines. **How other residents having potential to be affected will be identified and what corrective action is taken:** Residents do not reside in these areas, however activities occur near the one area fire place, and residents use the lobby occasionally to wait for a pick up from transportation near the other fire place in the lobby. The corrective action by equipping each fireplace with the necessary and required glass front and wire	08/01/2022

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	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. 3.1-19(b)		mesh screens shall be accomplished as well as installation of the carbon monoxide detectors. **Measures that will be put into place and what systemic changes to be made:** A member of the maintenance team shall visually inspect the fireplaces to ensure the glass fronts and the wire mesh screens are intact. These additional carbon monoxide detectors shall be automatically monitored by the fire system and alert our team when there is an issue that needs resolved. Annually, the fire system will be inspected by our licensed fire system contractor to ensure full functioning. **How will it be monitored to ensure no reoccurrence:** The inspection reports shall be shared and reviewed with the QAPI meeting participants quarterly for at least one year and evaluated to continue past one year if needed. **Date the systemic change will be completed:** The carbon monoxide detectors and components have been ordered and once delivered shall be installed immediately. We are left to the time table of the vendor for shipping. Plan is 8/1/22.	
K 0781 SS=F Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be			

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	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 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. 3.1-19(b)	K 0781	**K781: Portable Space Heaters** **Corrective Action to be accomplished:** The space heater was immediately removed upon finding. **How other residents having potential to be affected will be identified and what corrective action is taken:** The space heater was identified in a therapy space that is used for resident therapy services. At the time of the inspection, there were no resident present. The corrective action was to immediately remove the space heater from the area and instruct staff to not use a space heater in this space. Both have been accomplished on 7/7/22. **Measures that will be put into place and what systemic changes to be made:** Safety audits will include the checking of space heaters in resident occupied spaces and document findings. **How will it be monitored to ensure no reoccurrence:** A member of the environmental services team shall include safety audit findings in the QAPI meeting and reviewed quarterly. This shall continue for one year and evaluated to continue past one	07/07/2022

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			year if needed. **Date the systemic change will be completed:** The immediate removal and education to the staff has occurred and is now complete effective 7/7/2022.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 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. 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.			

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	Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 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. Findings include: 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., 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 0918	**K918: Electrical Systems-Essential Electric System** **Corrective Action to be accomplished:** A battery back up light will be installed at the location of the generator. **How other residents having potential to be affected will be identified and what corrective action is taken:** This could potentially affect all residents in the event of a generator failure. The corrective action will be to install the battery back up light at the location of the generator to ensure we are compliant with the requirements of this regulation. **Measures that will be put into place and what systemic changes to be made:** The maintenance tech shall include visual inspection of the light and battery power to the light at the same interval of the generator inspection monthly. **How will it be monitored to ensure no reoccurrence:** Inspection documentation shall be shared and reviewed during the QAPI meeting quarterly. This shall continue for one year and evaluated to continue if needed. **Date the systemic change will be completed:** The corrective action has been completed	07/20/2022

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