

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

PRINTED: 08/29/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155364</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/23/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BYRON HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1661 BEACON STREET</b> <b>FORT WAYNE, IN 46805</b>	
(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
{K 000}	<p><b>INITIAL COMMENTS</b></p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/23/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 08/23/24</p> <p>Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280</p> <p>At this PSR Survey, Byron Health Center was found in 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors, and in resident sleeping rooms. The facility consists of five (5) one-story comprehensive care wings and one (1) two-story residential care wing separated by a two-hour fire barrier, all connecting to a common services core. The building is partially protected by a type II ESS 300 kW diesel powered generator. The facility has a capacity of 120 and had a census of 108 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a</p>	{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 detached maintenance building that was not sprinklered.  Quality Review completed on 08/28/24	{K 000}		