

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2025
--	---	--	---

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

(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
F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of healthcare Complaint IN00453718.</p> <p>Complaint IN00453718 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 25, 26, 27 and 28, 2025.</p> <p>Facility number: 000240 Provider number: 155349 AIM number: 100274960</p> <p>Census Bed Type: SNF: 12 SNF/NF: 106 Total: 118</p> <p>Census Payor Type: Medicare: 3 Medicaid: 59 Other: 56 Total: 118</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed March 5, 2025.</p>	F 0000		
F 0880 SS=F Bldg. 00	<p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control</p> <p>Based on interview and record review, the facility failed to ensure water temperatures in facility</p>	F 0880	Saint Anne Home respectfully requests paper compliance for this	03/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elaine Wilson	COO	03/12/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2025
--	---	--	---

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

(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
	<p>storage tanks were monitored and legionella testing was performed routinely. 118 of 118 residents residing in the facility used water provided by the facility.</p> <p>Findings include:</p> <p>In an interview, on 2/27/25 at 1:04 PM, the Director of Nursing indicated she would provide policies and all records and logs pertaining to the facility's water management and legionella testing.</p> <p>A printed record of an email, dated 2/27/24 at 2:30 PM, indicated the Maintenance Director had contacted a company regarding a request for sample containers for legionella testing. The email indicated containers were being shipped that day or the following day for the facility to conduct legionella testing.</p> <p>A review of the facility assessment indicated the facility had a low probability of the occurrence of a resident with a legionella infection and a low capacity and performance to identify an issue.</p> <p>A review of 2024 temperature logs for water temperatures included spaces to record temperatures for hot water storage tanks 1 and 2 in the Nursing Home and hot water storage tanks 1 and 2 in the Rehabilitation section of the building. No values were documented in the spaces to record water temperatures of the water storage tanks in the Nursing Home or the Rehabilitation section of the building.</p> <p>In an interview, on 2/28/25 at 10:33 AM, the Maintenance Director indicated he was unable to obtain temperatures of water in the water storage tanks because no temperature gauge was present on the tanks.</p>		<p>citation.</p> <p>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Saint Anne Communities has sent in water samples to be tested for Legionella. The water samples were sent to HML Labs.</p> <p>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 in Saint Anne's have the potential to be affected.</p> <p>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 Communities will test for Legionella once per year in 4 locations throughout the campus.</p> <p>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 corrective action will be monitored during the monthly Quality Assurance Meetings,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/28/2025
--	---	--	---

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

(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
R 0000 Bldg. 00	<p>In an interview, on 2/28/25 at 10:33 AM, the Administrator indicated federal guidelines require the facility to provide a policy on water management for legionella and the policy should be followed. She indicated no legionella testing records were available for review and the policy had not been followed.</p> <p>An undated current policy titled Water Management Program- Legionella, provided by Administrator on 2/28/25 at 9:50 AM indicated the facility should maintain a temperature of 140 or above to prevent legionella growth. The policy also indicated legionella screening tests should be performed in 3-4 locations such as sinks or showers per floor and in the hot water tanks semi-annually.</p> <p>3.1-18(a)</p> <p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of healthcare Complaint IN00453718.</p> <p>Survey dates: February 25, 26, 27 and 28, 2025.</p> <p>Facility number:000240</p> <p>Residential Census: 74</p>	R 0000	<p>verifying that we have not passed one year without Legionella testing. This monitoring will be completed continuously during the monthly meeting.</p> <p>-</p> <p>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.</p> <p>The changes have been implemented Monday 3/10/2025 by sending in water samples to HML Labs.</p>	

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME			STREET ADDRESS, CITY, STATE, ZIP COD 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	
	Saint Anne Home was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed March 5, 2025				