

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/02/2013
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NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/02/13</p> <p>Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Canterbury Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with an attached two story wing was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors</p>	K010000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set for the statement of deficiencies. The plan of correction is prepared and/or soley executed because it is required by the provisions of federal and state law.	

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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	<p>and battery operated smoke detectors in all resident rooms. The facility has a capacity of 120 and had a census of 96 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including the emergency generator room, storage of the mower, maintenance equipment and supplies that was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/08/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 fire doors and 1 of 3 main kitchen doors were held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect any of the 17 residents on the 300 hall and at the main nurses' station in the event of a fire emergency and at least 20 residents in the assisted living transition unit dining room.</p> <p>Findings include:</p> <p>a. Based on observation with the Director of Maintenance on 04/02/13 at 12:58 p.m., the fire doors entering the 300 hall were obstructed by a large food cart. This was acknowledged by the Director of Maintenance at the time of observation.</p>	K010021	<p>Corrective action for alleged deficient practice: Food chart was removed from the entrance of 300 and the kick down door stop was removed. Staff were inserviced regarding the regulation of keeping fire doors clear from obstruction and automatic doors available to lock when fire system has activated. Identification of others with potential to be affected by alleged deficient practice: 100% visual audit was done of all fire doors in facility to ensure compliance with regulation. Systematic Change: Increased number of times that the maintenance department will round from once a day to twice a day (at beginning of shift and at the end of the shift.) Also will include education regarding this tag to our monthly all-staff inservices to serve as reminders to the staff. Monitoring of System</p>	05/01/2013			

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	b. the door between the main kitchen and the assisted living transition unit dining room was propped open with a kick down door stop. This was acknowledged by the Director of Maintenance at the time of observation.  3.1-19(b)		Change: The maintenance director will maintain a log of his rounds Mon-Fri. Those will be reviewed wkly by the administrator for compliance. Results of the audits will also be reviewed for the next 3 months through the CQI process, Any non-compliance noted will be immediately addressed, following the facility's disciplinary process.				

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the door to 2 of 4 hazardous areas, such as the main kitchen and a soiled linen storage area were self closing and latched into the door frame. This deficient practice could affect any of the 17 residents on the 300 hall and at least 27 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 04/02/13 from 12:58 p.m. to 2:13 p.m., the following was noted:</p> <p>a. the two doors between the main dining room and the main kitchen were self closing but were not equipped with latching hardware and failed to latch into the door frame. This was acknowledged by the Director of Maintenance at the</p>	K010029	<p>It is the policy of this facility to provide smoke resistant construction that protects hazardous areas that are separate from other spaces. Correction of alleged deficient practice: All latches have been replaced with latches that latch into the door frames. The vent in the 300 hall shower room has been fixed to ensure that it meets the smoke resistant requirement. Identification of others with potential to be affected of alleged deficient practice. The maintenance director conducted 100% audit of all fire doors and made sure they latched as required. No other areas were identified. System Change: The maintenance director will check all fire doors during daily rounds to ensure they are latching appropriately. Any identified issues will be addressed immediately. Maintenance department</p>	05/01/2013			

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	<p>time of observation.</p> <p>b. the 300 hall shower room used to store soiled linen had a corridor door which failed to latch into the door frame and had an eight inch by twenty inch vent in the door. Based on an interview with the Director of Maintenance at the time of observation, the soiled linen is stored in the shower room until it is taken to the laundry room.</p> <p>3.1-19(b)</p>		<p>inserviced to the new change. Monitoring of the system change: The maintenance director will maintain round logs and will turn those in to the administrator on a wkly basis. Any concerns or compliance issues noted will be reported to the CQI committee for further recommendations. This will be added to the CQI agenda for review once a month for 3 months.</p>		

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K010047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation, record review, and interview; the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was immediately visible for 1 of 8 ways to the exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect at least 27 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 04/02/13 at 11:55 a.m., there was no illuminated exit sign above the door leading to the service corridor. Based on review of the facilities Evacuation Plan map mounted on the wall near the main dining room, the service hall is used for an emergency exit. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>	K010047	<p>It is the policy of this facility to ensure exit and directional signs are displayed according to the life safety code. Corrective action regarding alleged deficient practice: A exit light was placed at the identified area leading to the service corridor. Identification of others with potential to be affected by alleged deficient practice: The maintenance director completed rounds at all exit doors, No other areas were identified. Systematic Change: The maintenance director will conduct daily of all exit doors to ensure they are lighted and accessible to all in the event there is a fire. Results of the rounds will be documented on a log that will be turned into the administrator on a wkly basis. Any concerns found will be addressed immediately. Monitoring of the Change: The maintenance director will document results of his rounds daily on a log, which will then be turned into the administrator on a wkly basis for review. Results of the audits will be shared with the CQI committee, once a month for the next 3 months for further recommendation if needed.</p>	05/01/2013	

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K010064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire extinguishers in 400 hall was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect any of the 25 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 04/02/13 at 12:55 p.m., access to the 400 hall fire extinguisher located in the corridor near resident room 402 was obstructed by a portable lift. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>	K010064	<p>It is the policy of this facility to ensure fire extinguishers are readily and immediately accessible. Corrective action for alleged deficient practice: The fire extinguisher on 400 hall was cleared of obstruction and objects. Staff inserviced regarding the regulation regarding this. Identification of other potential to be affected by alleged deficient practice: The maintenance director conducted rounds on all halls and ensured that all fire extinguishers were accessible for immediate access. System Change: The maintenance department will increase rounds during the day to ensure that all fire extinguishers are free from obstruction. The housekeeping department will be responsible to monitor as well while they are on the hall to ensure nothing blocks the fire extinguishers. The staff educationer will add review of the fire extinguishers to her on-going staff inservices to help them be reminded of the regulation. Monitoring of the system change: The maintenance director will keep a log of his rounds and results. The log will be turned in wkly to the administrator for review. Any non-compliance will be addressed</p>	05/01/2013

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			immediately with the staff to correct and habitual offenders will receive disciplinary action and/or termination for non-compliance. The log results will be reported to the CQI once a month for 3 months for recommendations and/or to determine need for further monitoring.		

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K010067 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 dampers in the ceiling vents were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice was not in a resident care area but could affect staff.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 04/02/13 during a tour from 1:43 p.m. to 2:49 p.m., there were fire/smoke dampers in the ceiling fresh air intakes of the three water heater rooms.</p>	K010067	<p>It is the policy of the facility to monitor and ensure that vents are maintained per the regulations. Corrective action for alleged deficient practice: All vents in the facility were inspected on 4-17-14. Identification of other potential to be affected by alleged deficient practice: The maintenance director rounded each mechanical room and noted there are 4 dampers in the facility. All dampers were inspected. System change: A automatic schedule has been set up for maintenance inspections of the dampers with our fire alarm monitoring provider. These inspections are set up for every 3 years, verses the every 4 years as required. Monitoring of the system change: The maintenance director will check on dampers on a monthly basis during his facility rounds to ensure they are in working condition. Any concerns will be addressed with our vendor to be fixed. The vendor will supply the facility with a record of the results of the inspections, which the administrator will review with the maintenance director and will maintain in the contract binder.</p>	05/01/2013
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	<p>Based on an interview with the Director of Maintenance at the time of observations, he was not aware of the dampers, the damper have not been inspected and he has no documentation to show the inspections were done prior to his arrival at the facility.</p> <p>3.1-19(b)</p>		<p>Results of the inspection will be reported to the CQI committee on the month that the inspection occurs.</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect at least 27 residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 04/02/13 at 2:10 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on interview with the Director of Maintenance on 2:30 p.m., the</p>	K010130	<p>It is the policy of this facility to ensure that all rolling windows/doors are maintained within accordance to life safety code. Corrective action for alleged deficient practice: The rolling window was inspected on 4-17-13. The maintenance director was educated regarding the requirement for annual inspections on this equipment. Identification of other potential to be affected by alleged deficient practice: The facility only has 1 rolling window located on premises. Systematic Change: The rolling window was set up for annual inspections to happen automatically through our vender who monitors the fire alarm system. Monitoring of the system change: The company who provides the inspections will turn in visit reports which will be copied to the administrator. The administrator will review the results each time with the maintenance director to ensure compliance.</p>	05/01/2013			

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	rolling fire door does not have a current inspection.  3.1-19(b)			

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load.</li> <li>2. When the battery charger is malfunctioning.</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure.</li> <li>2. Low water temperature.</li> <li>3. Excessive water temperature.</li> <li>4. Low fuel - when the main fuel storage</li> </ol>	K010144	<p>It is the policy of this facility to provide annunciator panels for the generator in accordance with life safety code. The facility was in process of having the panel repaired at the time of this survey. Corrective action for alleged deficient practice: The panel was repaired. Identification of other potential to be affected by alleged deficient practice: The maintenance director completed a facility check on all remaining panels and found no issues. Systematic change: The maintenance director will inform the administrator of equipment that is down and has to wait on parts for the repair so a decision can be made to seek out alternatives to shorten the timeframe that at the equipment is down. The maintenance director has been educated to the new change. Monitoring of the new system: The Maintenance director will keep a log that will track repairs of equipment and time frames of when parts are on order. The Administrator will review this log with the maintenance director on a wklly basis to ensure that the facility is handling repairs in a timely fashion. Results of the log reviews will be reported to the</p>	05/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  04/02/2013
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835		
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	<p>tank contains less than a 3-hour operating supply.</p> <p>5. Overcrank (failed to start).</p> <p>6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 04/02/13 at 2:08 p.m., the generator annunciator panel was not operational at this time. Based on an interview with the Director of Maintenance at the time of observation, he stated the panel was accidentally shorted out last week and he was in the process of replacing it.</p> <p>3-1.19(b)</p>		<p>CQI monthly for 3 months to identify any trends or need for further monitoring.</p>		