

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE FORT WAYNE, IN 46805
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/01/12</p> <p>Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Life Care Center of Fort Wayne 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 was determined to be of Type III (200)</p>	K0000	<p>This plan of correction is the facility's credible allegation of compliance. 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 forth in the statement of deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.</p>	

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>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 125 and had a census of 66 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and was found in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered, except the following closets; resident room 19, 20 and 50 and the laundry room closet. All areas providing facility services were sprinklered, except a maintenance office/workshop/storage building.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 12 residents.</p> <p>Finding include:</p> <p>Based on observation with the Director of Maintenance on 11/01/12 at 1:45 p.m., the coordinating device at the smoke barrier doors near resident room</p>	K0027	<p><u>Corrective action(s) for those identified:</u> The coordinating device at the smoke barrier doors near resident room 25 was repaired on 11/16/12, so that the doors properly close and provide the required smoke barrier.</p> <p><u>Identification of others potentially affected:</u> The maintenance director manually tested the operation of all sets of smoke barrier doors, and determined that they close properly to provide the required smoke barrier.</p> <p><u>Measures to prevent recurrence:</u> Per the facility's preventive maintenance program (TELS), monthly the maintenance director will manually test the operation of all sets of smoke barrier doors to identify whether they close properly to provide the required smoke barrier. Any set of doors identified as not closing properly will be repaired, so that the doors close properly to provide the required smoke barrier.</p> <p><u>Monitoring:</u> Monthly the maintenance</p>	12/01/2012	

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	<p>25 failed to operate properly when manually tested. The device prevented the doors from closing completely leaving a six inch gap at the top of the doors. This was confirmed by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>		<p>director will report the results of tests and any repairs made to the Performance Improvement (PI) Committee (also known as the Quality Assurance Committee). The PI Committee will review these reports and make any further recommendations necessary to ensure that smoke barrier doors are functioning properly.</p>		

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 5 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 23 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on</p>	K0038	<p><u>Corrective action(s) for those identified:</u> At the exit doors identified, instructions for entering the exit code will be posted, so that the means of egress is readily accessible for those residents whose needs do not require specialized security measures.</p> <p><u>Identification of others potentially affected:</u> At each exit door, except for Denton hall where the clinical needs of the residents require specialized security measures, instructions for entering the exit code will be posted.</p> <p><u>Measures to prevent recurrence:</u> Weekly for four weeks, then monthly, the maintenance director will inspect the exit door areas to ensure that the instructions for entering the exit code are posted, so that residents, except for those on the Denton hall whose needs require specialized security measures, have means of egress readily accessible. If the maintenance director finds that any instructions are missing, he will re-post the instructions for entering the exit code.</p> <p><u>Monitoring:</u> Monthly the maintenance</p>	12/01/2012	

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	<p>11/01/12 during the tour from 1:03 p.m. to 3:00 p.m., all exit doors, except Benton hall were magnetically locked and could be opened by entering a code, but the code was not posted. Based on an interview with the Executive Director at 2:45 p.m. during the exit conference, twenty three residents are without a clinical diagnosis requiring specialist security measures. This was confirmed by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>		<p>director will report the results of inspections and any actions taken to the PI Committee. The PI Committee will review these reports and make any further recommendations necessary to ensure that means of egress through exits is readily available to residents.</p>		

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K0052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure all required inspection documentation for 1 of 1 fire alarm systems was available accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 7.5.2.2 requires a permanent record of all inspections, testing and maintenance shall be provided that includes the following information:</p> <p>(1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection and business address (6) Name, address and representative of approving agency (7) Designation of detector(s) tested (8) Functional test of detectors (9) Functional test of required sequence of operations</p>	K0052	<p><u>Corrective action(s) for those identified:</u> The maintenance director obtained documentation from the contracted provider for the annual function testing of the fire alarm system that was conducted in May 2012. This documentation provided an itemized listing of test results for all components and devices of the fire alarm system.</p> <p><u>Identification of others potentially affected:</u> The maintenance director reviewed with the contracted service provider the requirements for the permanent record of inspections, testing and maintenance of the fire alarm system. All components and devices of the fire alarm system are included in the service provider's annual inspection and testing and are reflected in the related documentation.</p> <p><u>Measures to prevent recurrence:</u> Upon the completion of the annual function testing of the fire alarm system by the contracted provider, the maintenance director will review the written</p>	12/01/2012			

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	<p>(10) Check of all smoke detectors (11) Testing of heat detectors (12) Other tests as required by equipment manufacturers (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester (15) Disposition of problems identified during test This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the SafeCare fire alarm inspections with the Director of Maintenance on 11/01/12 at 2:29 p.m., the SafeCare "Inspection and Testing Form" dated 11/28/11 did not have itemized documentation available listing test results of all components and devices of the fire alarm system. Based on an interview with the Director of Maintenance at the time of record review, no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p>results of the testing, in order to ensure that there is an itemized listing of testing results for all components and devices of the fire alarm system. In the event that any components or devices are not listed on the test results, the maintenance director will contact the contracted provider and request that the required testing be completed and/or documented.</p> <p><u>Monitoring:</u> The maintenance director will report the results of his reviews of the function testing of the fire alarm system, as well as actions taken to ensure the testing is complete, to the PI Committee. The PI Committee will review these reports and make any further recommendations necessary to ensure that testing of the fire alarm system includes the itemized listing of test results of all components and devices.</p>		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 3 of 61 resident room closets and 1 of 1 laundry room closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems to provide complete coverage for all portions of the building. This deficient practice could affect 3 residents and laundry staff.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 11/01/12 from 12:08 p.m. to 1:11 p.m., the closets in resident</p>	K0056	<p><u>Corrective action(s) for those identified:</u></p> <p>1. Sprinkler coverage will be provided to the closets in resident rooms 19 and 20 and the laundry room closet. Upon further inspection, sprinkler coverage was identified as already in place in resident room 50.</p> <p>2. One of the sprinkler heads in the beauty shop will be relocated, so that they are no longer closer to one another than is allowed.</p> <p><u>Identification of others potentially affected:</u></p> <p>The entire facility was inspected by the maintenance director and the contracted service provider for the sprinkler system, in order to identify any other areas lacking the required sprinkler coverage or areas where sprinkler heads are not at required distance from one another. Where required, any additional sprinkler coverage will</p>	12/01/2012			

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	<p>rooms 19, 20, and 50 and the laundry room closet lacked sprinkler coverage. This was confirmed by the Director of Maintenance at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 Beauty Shop sprinkler heads were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect 2 resident in the Beauty Shop in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 11/01/12 at 12:11 p.m., the Beauty Shop had two sprinkler heads located two feet six inches apart. Measurements were provided by the Director of Maintenance at the time of observation.</p>		<p>be provided. Where required, any further corrective action related to sprinkler head placement will be accomplished.</p> <p><u>Measures to prevent recurrence:</u> With each quarterly sprinkler system inspection, the maintenance director will consult with the inspection provider regarding any additional sprinkler coverage needed or any need to correct the proximity of sprinkler heads to one another. Any areas identified as needing attention will be serviced, in order to provide the required sprinkler coverage.</p> <p><u>Monitoring:</u> Quarterly the maintenance director will report the results of sprinkler system inspections, as well as actions taken to ensure that sprinkler coverage is provided as required, to the PI Committee. The PI Committee will review these reports and make any further recommendations necessary to ensure that sprinkler coverage is provided as required.</p>				

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 interior areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 33 residents on Benton hall and near the Preston nurses' station.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance on 11/01/12 at 11:44 a.m., the door</p>	K0143	<p><u>Corrective action(s) for those identified:</u> The door to the oxygen room will be replaced with a door of 1-hour fire-resistive construction.</p> <p><u>Identification of others potentially affected:</u> This is the only area in the facility where transferring of oxygen occurs.</p> <p><u>Measures to prevent recurrence:</u> Quarterly the maintenance director will inspect the area used for transfer of oxygen. The maintenance director will report any needed maintenance or repairs to the administrator and will arrange for such work to be done, in order to ensure that the area is separated from any area used by residents by a fire barrier</p>	12/01/2012	

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	<p>to the oxygen room was a nonrated metal door. Based on an interview with the Director of Maintenance at the time of observation, he could not confirm the metal door was a one hour fire rated door.</p> <p>3.1-19(b)</p>		<p>of 1-hour fire-resistive construction.</p> <p><u>Monitoring:</u> Quarterly the maintenance director will report the results of his inspection of the area used for the transfer of oxygen, as well as actions taken, to the PI Committee. The PI Committee will review these reports and make any further recommendations necessary to ensure that the area is separated from any area used by residents by a fire barrier of 1-hour fire-resistive construction.</p>		