

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 03/19/2015
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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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K 000 Bldg. 01	<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: 03/19/15</p> <p>Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930</p> <p>Surveyor: Thomas Forbes, 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</p>	K 000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review. We have included our re-education and monitoring tools for your convenience. Please feel free to contact Maya Kaczmarek at 260-580-6025 should you need additional information to assist you with your consideration.</p>	
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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 025 SS=E Bldg. 01	<p>corridors, areas open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 142 and had a census of 81 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 Dennis Austill, Life Safety Code Specialist on 03/23/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully</p>			

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	<p>ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice can affect 24 residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Director on 03/19/15 between 10:25 a.m. and 11:30 a.m., the following penetrations were noted:</p> <p>a. two unsealed penetrations through the ceiling measuring a half of an inch around wires in the 200 hall nursing supply room.</p> <p>b. one unsealed penetration through the ceiling measuring a half of an inch around the wires in the 200 hall mop closet.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p>	K 025	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1) 200 hall nursing supply: filled penetration with fire caulk2) 200 hall mop closet: filled penetration with fire caulk 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; 1) One time audit conducted by Maintenance Director with no additional findings. All residents had potential to be affectedWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;1) Weekly audits of the facility smoke barriers by Maintenance Director or designee for four weeks and then twice a month for two months. 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; 1) Maintenance Director to conduct followup checks anytime a contractor has been in the facility to ensure the smoke barriers are maintained and will provide a one hour fire resistance rating.</p>	04/18/2015			

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K 029 SS=E Bldg. 01	<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 smoke resistance in 1 of 1 hazardous areas such as a hot water furnace room. This deficient practice could affect 19 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Director on 03/19/15 at 11:37 a.m., in the 400 mechanical room, containing a hot water heater, there were two unsealed penetrations around wires measuring from one fourth of an inch to one half of an inch. Based on interview at the time of observation, the measurements were provided by the Maintenance Director.</p>	K 029	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1) 400 hall mechanical room: filled penetration by ceilings/boilers with red fire caulk.2)500 hall office: Filled two small holes where a cable line was ran through the wall. 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; 1) One time audit conducted by Maintenance Director with no additional findings. All residents had potential to be affectedWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;1) Weekly audits of the facility smoke barriers by MD or designee for</p>	04/18/2015

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K 048 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on observation and interview, the facility failed to ensure the door to 1 of 1 soiled linen closets, a hazardous area, were provided with a self closer and would latch into the frame. This deficient practice could affect 20 residents in the 300 hall family room.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Director on 03/19/15 at 12:38 p.m., the door to the closet marked soiled linens, which did contain soiled linen, latch into the door frame but did not self close due to the lack of a self closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the</p>	K 048	<p>four weeks and then twice a month for two months. 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; 1) Maintenance Director to conduct followup checks anytime a contractor has been in the facility to ensure the smoke barriers are maintained and will provide a one hour fire resistance rating.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1) Installed self closer on identified utility door 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; 1) One time audit conducted by Maintenance Director with no additional findings. All residents had potential to be affected What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; 1) Weekly audits to be conducted by Maintenance Director or designee for four weeks and then twice a month for two months. How the corrective action(s) will</p>	04/01/2015			

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	<p>lack of a self closer on the room marked soiled linens.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to provide a written plan that included the response to battery operated smoke alarms in the resident rooms in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 03/19/15 at 10:15 a.m., the "Fire Plan" did not address the response to the activation of a battery operated smoke alarms in the resident rooms. Based on interview at the</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; 1) Maintenance Director to conduct quarterly audits on an ongoing basis per policy.</p>	

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K 062 SS=E Bldg. 01	<p>time of record review, the lack of response to the activation of a battery operated smoke alarm was confirmed by the Maintenance Director.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace 1 of 3 automatic sprinklers in the 400 hall shower which was corroded. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 1 resident and 2 staff in the 400 shower room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on</p>	K 062	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1) Corroded sprinkler head has been corrected in the 400 hall shower room. 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; 1) One time audit conducted by Maintenance Director with no additional findings. 2) All residents had potential to be affected what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; 1) Weekly audits of the facility sprinkler system in all shower rooms by Maintenance Director or designee for four weeks and then twice a month for two months.</p>	04/18/2015

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K 066 SS=F Bldg. 01	<p>03/19/15 at 11:25 a.m., one of three automatic sprinklers in the 400 hall shower was corroded with a green substance. Based on interview at the time of the observation, the Maintenance Director Acknowledged the sprinkler head in the 400 hall shower was corroded.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observations and interview, the</p>	K 066	<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; 1) Maintenance Director to conduct an audit monthly of all sprinkler heads in the facility on an ongoing basis.</p> <p>What corrective action(s) will be accomplished for those residents</p>	04/18/2015

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	<p>facility failed to ensure cigarette butts were disposed into a noncombustible container which was provided for 2 of 2 areas where smoking was permitted. This deficient practice could affect any residents using the 200 hall courtyard, and any resident or staff utilizing the service hall exit during a fire emergency.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Director on 03/19/15 at 11:30 a.m. and 12:13 p.m., the staff smoking area outside of the service hall exit and the resident smoking area in the 200 hall court yard was provided with approved metal containers for disposing cigarette butts, but in both areas there was combustible trash mixed with cigarette butts in the approved metal containers. Also, the resident smoking area had over 100 cigarette butts on the ground around the court yard. Based on interview at the time of observation, the Maintenance Director acknowledged the facility's employee and resident smoking areas had cigarette butts disposed with paper products and cigarette butts on the ground.</p> <p>3.1-19(b)</p>		<p>found to have been affected by the deficient practice; The facility has orderd smoke towers that do not allow for trash to be place inside (3.27.15).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; 100% audit complete. All residents had potential to be affectedWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Resident council and staff to be educated on correct disposal of trash and disposal of cigarette butts. 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; The Administrator or Maintenance Director will review weekly for four weeks to ensure that the new smoke towers are functioning correctly. Then then this will then be reviewed twice a month for two months and then taken through QA.</p>	

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K 075 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to properly maintain 2 of 2 unattended trash and soiled linen collection receptacles with a capacity of more than 32 gallons within a 64 square foot area, located in a resident room. This deficient practice affects visitors, staff and 25 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Director on 03/19/15 at 12:00 p.m., there were two collection receptacles standing side by side in room 412. The receptacles were not mobile, one was marked "trash" and the second marked "soiled linen." The room was open to the corridor and the door did not self close. Based on interview at the time of observation, the Maintenance Director acknowledged the capacity of the two collection receptacles</p>	K 075	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; New trash and soiled linen collection receptacles to be ordered that will encompass less than 32 gallons within 64 square feet. 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; 100% audit complete. All residents had potential to be affectedWhat measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Old soiled linen collection receptables to be disposed of and switched with the above referenced receptaclesHow 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; Daily audits by Maintenance Director or</p>	04/18/2015

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K 154 SS=C Bldg. 01	<p>exceeded 32 gallons.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire watch policies provided a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department</p>	K 154	<p>designee until new receptacles are placed on the hall. MD or designee will ensure that more than 32 gallons of soiled linen is not with in 64 square feet.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility has a complete written policy containing procedures to be followed in the event that the automatic sprinkler has to be placed out of order. The facility has added that the designated person(s) shall not have other duties or responsibilities while conducting the fire watch. The Fire Watch Policy has been reviewed. 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; 100% audit complete. All residents had potential to be affectedWhat measures will be put into place or what systemic changes will be</p>	04/18/2015

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	<p>be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Watch Policy" with the Maintenance Director on 03/19/15 at 10:09 a.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not state the designated person(s) shall not have other duties or responsibilities while conducting the fire watch. Also, the last time the "Fire Watch Policy" was reviewed was in 2009. Based on an interview at the time of record review, the Maintenance Director acknowledged the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall be assigned no other duties and that the date of last review was in 2009.</p> <p>3.1-19(b)</p>		<p>made to ensure that the deficient practice does not recur; Policy was corrected. 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; The Administrator and Maintenance Director will review annually.</p>	

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 03/19/2015
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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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K 155 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed ensure 1 of 1 fire watch policies provided a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affects all</p>	K 155	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility has a complete written policy containing procedures to be followed in the event that the automatic sprinkler has to be placed out of order. The facility has added that the designated person(s) shall not have other duties or responsibilities while conducting the fire watch. The Fire Watch Policy has been reviewed. 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; 100% audit complete. All residents had potential to be affected What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Policy was corrected. 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; The Administrator and Maintenance Director will review</p>	04/18/2015
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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 03/19/2015
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