

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
--	---

(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 0000 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: 10/27/15</p> <p>Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910</p> <p>At this Life Safety Code survey, Signature Healthcare 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity 112 and had a census of 79 at</p>	K 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
--	---

(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 0018 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas providing customary access to the residents were sprinklered. The facility had a detached garage and three sheds providing facility services including storage of old equipment, new beds, mattresses and maintenance supplies that were not sprinklered.</p> <p>Quality Review completed 10/28/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 12 of 77 resident room doors of the facility protecting corridor openings. This deficient practice could affect up to 50 residents of the facility.</p>	K 0018	<p>K018 / SS=E: Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 12 of 77 resident room doors of the facility protecting corridor openings. 1. The following corrective actions will be accomplished for those</p>	11/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/27/2015	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(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>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director on 10/27/15 between 10:03 a.m. and 12:11 p.m., the corridor doors, which were self closing doors held open with a magnet that released with the fire alarm, to resident rooms 101, 104, 108, 111, 112, 117, 124, 125, 136, 208, 212, 222, and 231, were obstructed from closing and latching by the open restroom door within each room. Based on interview at the time of observation, this was acknowledged by the Plant Operations Director.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 77 resident room doors closed and latched into the door frame. This deficient practice could affect any of the 26 residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director on 10/27/15 at 11:01 a.m., the corridor door to resident room 214 failed to latch into the door frame. Based on</p>				<p>residents found to be affected by the deficient practice; a. All staff will be re-educated 11/12/15 on the need to insure that resident bathroomdoors are kept shut when not being used by a resident to insure proper closingof automatic release doors during emergency procedures. b. The striker plate on the door of room #214 was adjusted by the maintenance director11/04/15 to achieve proper closing and latching of the deficient door.</p> <p>2. Other residents having the potential to be affected by the same deficient practice will be identified through corrective actions including; a. All staff will be re-educated11/12/15 on the need to insure that resident bathroom doors are kept shut whennot being used by a resident to insure proper closing of automatic releasedoors during emergency procedures.</p> <p>3. Measures that will be put into place to insure that the deficient practice does not recur include; a. Maintenance Director/ or designee will assess compliance during monthly fire drills to insure staff is following this directive. b. Maintenance Director/ or designee will audit all resident corridor doors to insurecompliance; weekly x4 weeks, thenbi-weekly x8 weeks, then monthly x3 months.</p> <p>4. The corrective actions will be monitored to insure the deficient practice does not recur by</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
--	---

(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 0021 SS=E Bldg. 01	<p>interview at the time of observation, this was acknowledged by the Plant Operations Director.</p> <p>3.1-19(b)</p> <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 the 1 of 6 corridors doors to hazardous areas, such as a soiled linen room, would self close and latch into the frame. This deficient practice could affect 12 residents on the serenity hallway.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations</p>	K 0021	<p>presenting the findings of the audits at the monthly QA/PI meetings.</p> <p>5. The systemic changes will be completed by 11/12/2105.</p> <p>K021 / SS=E: Based on observation during a tour of the facility with Plant operations Director on 10/27/15 at 11:31 am, the corridor door of the Serenity Hall soiled utility room, which contained trash and soiled linen, was not equipped with an automatically closing device.</p> <p>1. The following corrective actions will be accomplished for those residents found to be affected by the deficient practice;</p> <p>a. The corridor door of the serenity unit was equipped with</p>	11/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/27/2015	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815			
(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 0029 SS=E Bldg. 01	<p>Director on 10/27/15 at 11:31 a.m., the corridor door of the serenity hall soiled utility room, which contained trash and soiled linen, was not equipped with an automatically closing device. Based on interview, this was acknowledged by the Plant Operations Director at the time of observation.</p> <p>3.1-19(b)</p> <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</p>				<p>an automatic closing device by the maintenance director 11/04/15to ensure that the door would self-close and latch into the frame.</p> <p>2. Other residents having the potential to be affected by the same deficient practice will be identified through corrective actions including; a. Maintenance Director /or designee performed 100% audit 10/27/15 of all soiled utility room doors to insure proper closing mechanisms are intact.</p> <p>3. Measures that will be put into place to ensure that the deficient practice does not recur include; a. Maintenance Director/ or designee will audit all resident corridor doors to ensure compliance; weekly x4 weeks, then bi-weekly x8 weeks, then monthly x3 months.</p> <p>4. The corrective actions will be monitored to insure the deficient practice does not recur by presenting the findings of the audits at the monthly QA/PI meetings.</p> <p>5. The systemic changes will be completed by 11/12/2105.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
--	---

(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>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 1 of 6 corridors doors to hazardous areas, such as a soiled linen room, would self close and latch into the frame. This deficient practice could affect 12 residents on the serenity hallway.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operations Director on 10/27/15 at 11:31 a.m., the corridor door of the serenity hall soiled utility room, which contained trash and soiled linen, was not equipped with an automatically closing device.</p> <p>Based on interview, this was acknowledged by the Plant Operations Director at the time of observation.</p> <p>3.1-19(b)</p>	K 0029	<p>K029 SS=E: Based on observation and interview, the facility failed to ensure 1 of 6 doors to hazardous areas, such as a soiled utility room, would self-close and latch into the frame.</p> <p>1. The following corrective actions will be accomplished for those residents found to be affected by the deficient practice; a. The corridor door of the serenityunit was equipped with an automatic closing device by the maintenance director 11/04/15to insure that the door would self-close and latch into the frame.</p> <p>2. Other residents having the potential to be affected by the same deficient practice will be identified through corrective actions including; a. Maintenance Director /or designeeperformed a 100% audit 10/27/15 of all soiled utility room doors to insureproper closing mechanisms are intact.</p> <p>3. Measures that will be put into place to insure that the deficient practice does not recur include; a. Maintenance Director/ or designee willaudit all resident corridor doors to insure compliance; weekly x4 weeks, then bi-weekly x8 weeks,then monthly x3 months.</p>	11/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 10/27/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815		
(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	
			4. The corrective actions will be monitored to insure the deficient practice does not recur by presenting the findings of the audits at the monthly QA/PI meetings. 5. The systemic changes will be completed by 11/12/2105.		