| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155446 | | 03/10/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COVINGTON MANOR HEALTH AND REHABILITATION CENTER | 5700 WILKIE DR<br>FORT WAYNE, IN 46804 |

| (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 |
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| K 0000<br><br>Bldg. 01 | 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).<br><br>Survey Date: 03/10/16<br><br>Facility Number: 000476<br>Provider Number: 155446<br>AIM Number: 100290870<br><br>At this Life Safety Code survey, Covington Manor Health 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) and 410 IAC 16.2. The original building consisting of the West wing, East wing, Bed and Breakfast unit and the service hall was surveyed with Chapter 19, Existing Health Care Occupancies.<br><br>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 corridors and areas open to the corridors | K 0000 | This plan of correction constitutes the facility's written 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 the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.<br>This facility is requesting desk review. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| | and battery operated smoke detector in the resident rooms. The facility has a capacity of 149 and had a census of 86 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage.<br><br>Quality Review completed on 03/11/16 - DA | | | |
| K 0029<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>One hour fire rated construction (with o 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<br>Based on observation and interview, the facility failed to ensure 2 of 2 dining room doors open to the kitchen automatically close and latch into the door frame. This deficient practice could affect up to 25 residents using the dining room. | K 0029 | The identified door was repaired on 3/16/16. (Receipts attached)<br>No other doors were found to not latch.<br>Proper latching of doors will be audited weekly by the Maintenance/Assistant Maintenance Director. Results will be presented monthly to the QA committee times | 04/09/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | X3) DATE SURVEY COMPLETED |
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| | Findings include:<br><br>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/10/16 at 10:17 a.m., there were two sets of double doors from the corridor to the dining room that was open to the kitchen. Both set of doors were equipped with a self-closing device but only one of the doors on each set latched into the frame. Based on Interview at the time of observation. the Maintenance Supervisor acknowledged that one of the doors on each set of doors did not latch into the frame.<br><br>3.1-19(b) | | 6 months. | |
| K 0066<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Smoking regulations are adopted and include no less than the following provisions:<br><br>(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.<br><br>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 03/10/2016 |
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| | (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.<br><br>(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<br>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents was maintained. This deficient practice could affect up to 25 residents using the service hall exit in the event of any emergency.<br><br>Findings include:<br><br>Based on an observation during a tour of the facility with the Maintenance Supervisor on 03/10/16 at 10:40 a.m., in the outside staff designated smoking area by the service hall exit there was a trash can containing cigarette butts and combustible material. The area was provided with a "smoker ' s oasis" which is a metal container with a long neck used for cigarette butts. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor.<br><br>3.1-19(b) | K 0066 | The identified trash container was relocated away from the employee smoking area on 3/17/16.<br>No other smoking areas were found to have trash containers.<br>Staff was in serviced on smoking policy.<br>No QA needed as trash container has been moved from area. | 04/09/2016 |

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| K 0130<br>SS=E<br>Bldg. 01 | NFPA 101<br>MISCELLANEOUS<br>OTHER LSC DEFICIENCY NOT ON 2786<br>Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system 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 25 residents in the main dining room.<br><br>Findings include:<br><br>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/10/16 at 11:35 a.m., there was one metal rolling fire door protecting the opening from the kitchen to the main | K 0130 | Papaerwork for inspection or test to check for proper operation and full closure of the metal curtain was located and is attached to POC.<br>There are no other full metal curtains in the facility.<br>Inspection is done yearly, no QA needed. Inspection tag is in place. | 04/09/2016 |

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| | dining room without an inspection tag. Based on records review with the Maintenance Supervisor on 03/10/16 at 10:00 a.m. no documentation of an annual inspection could be provided. Based on interview at the time of observation the maintenance stated and inspection was conducted but could not find the documentation of an annual inspection or test to check for proper operation and full closure of the metal curtain.<br><br>3.1-19(b) | | | |
| K 0147<br>SS=E<br>Bldg. 01 | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Electrical wiring and equipment shall be in accordance with National Electrical Code.<br>9-1.2 (NFPA 99) 18.9.1, 19.9.1<br>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect facility 2 residents in room 109 and 10 residents outside of the administration offices. | K 0147 | Power strips were removed from identified areas.<br>Rooms/offices were inspected for additional power strip usage with no other power strips identified.<br>Staff was in serviced on the appropriate use of power strips.<br>Guardian Angels will monitor rooms daily M-F for appropriate power strip usage with results to monthly QA times 6 months. | 04/09/2016 |

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| | 155446 | A. BUILDING 01 / B. WING | 03/10/2016 |

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| | Findings include:<br><br>Based on observations during a tour of the facility with the Maintenance Supervisor on 03/10/16 between 11:00 a.m. 12:00 p.m., The following areas had equipment with a high current draw plugged into power strips:<br>a) a refrigerator was plugged into an extension cord power strip in the Social Services office.<br>b) Two refrigerators were plugged into an extension cord power strip in the Director of staff development office.<br>c) a microwave was plugged into an extension cord power strip in room 109.<br>Based on interview at the Time of observation. The Maintenance supervisor acknowledged the extension cord and power strip.<br><br>3.1-19(b) | | | |
| K 0000<br><br>Bldg. 02 | 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).<br><br>Survey Date: 03/10/16 | K 0000 | This plan of correction constitutes the facility's written 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 the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING | X3) DATE SURVEY COMPLETED |
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| | 155446 | | 03/10/2016 |

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| | Facility Number: 000476<br>Provider Number: 155446<br>AIM Number: 100290870<br><br>At this Life Safety Code survey, Covington Manor Health 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) and 410 IAC 16.2. The new section of the building consisting of the Rehabilitation wing was surveyed with Chapter 18, New Health Care Occupancies.<br><br>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 corridors and areas open to the corridors and battery operated smoke detector in the resident rooms. The facility has a capacity of 149 and had a census of 86 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage. | | and safety code section 1280 and 42 CFR 483.<br>This facility is requesting desk review. | |

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| | Quality Review completed on 03/11/16 - DA | | | |