

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155756	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/12/2015
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NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804
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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: 11/12/15</p> <p>Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400</p> <p>At this Life Safety Code survey, Coventry Meadows 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 18, New 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 of 150 and had a census of 142 at the time of this survey.</p>	K 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after December 4, 2015.</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 0029 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 11/16/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure penetrations in a 1 of 1 hazardous areas were maintained to provide a one hour fire resistance rating. This deficient was not in a resident care area but could affect staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 11/12/15 at 10:10 a.m.; in the ceiling of the mechanical/riser room, which contained a hot water heater, there were six unsealed fourth of an inch penetrations around electric conduit and wires. Based on interview at the time of</p>	K 0029	<p><b>K 029 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure that all hazardous areas are protected in accordance with 8.4 The areas are enclosed with a one hour fire rated barrier, with a ¾ hour fire-rated door, without windows. Doors are self-closing or automatic closing in accordance with 7.2.1.8 However, based on the alleged deficient practice the following has been implemented:</p>	12/04/2015

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	<p>observation, the Environmental Supervisor acknowledged and provided the size of penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 oxygen storage rooms in the service hall was provided with self closing device causing the doors to automatically close and latch into the door frame. This deficient was not in a resident care area but could affect staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 11/12/15 at 10:03 a.m.; the door to the oxygen storage room on the service hall was equipped with a self closing device, but failed to latch into the frame due to the door sticking on the floor. Based on interview, this was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 2 corridor doors to the kitchen was provided with</p>		<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>· The ceiling of the mechanical/riser room was re-sealed where the electric conduit and wires penetrate the ceiling. They were re-sealed on or before December 12, 2015.</li> <li>· The oxygen storage room door was adjusted so that it closes freely and self closes on November 12th, 2015.</li> <li>· The kitchen door self closer was replaced with a different model to ensure it self-closes and latches on November 17th, 2015.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b></p> <ul style="list-style-type: none"> <li>· All staff that use the mechanical/riser room, kitchen and oxygen room have the potential to be affected by the alleged deficient practice.</li> </ul>	

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	<p>self closing device causing the doors to automatically close and latch into the door frame. This deficient was not in a resident care area but could affect staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Environmental Supervisor on 11/12/15 at 10:10 a.m.; the door to the kitchen from the service hall was equipped with a self closing device, but failed to latch into the frame. Based on interview, this was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<ul style="list-style-type: none"> <li>· All ceiling penetrations in the building were checked to ensure there was a seal on or before December 4th, 2015.</li> <li>· The Oxygen room door and kitchen door will be checked on an on-going basis by the Maintenance Supervisor to ensure it self-closes and latches.</li> </ul> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Director or Designee will check all ceiling penetrations on a weekly basis to ensure they are sealed.</li> <li>· The Oxygen Room Door and kitchen door will be checked on an on-going basis by the Maintenance Supervisor to ensure it self-closes and latches.</li> <li>· The Maintenance Director/Designee will in-service the maintenance assistant on checking for ceiling penetrations and how to re-seal them as well as self-closing doors such as the Oxygen room door and kitchen door. In-service will be</li> </ul>	

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K 0052 SS=F Bldg. 01	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		<p>completed by 12/4/15.</p> <ul style="list-style-type: none"> <li>The Maintenance Director is in charge of program compliance</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>A CQI monitoring tool called Ceiling Penetrations and self closing doors will be utilized every week x 4, monthly x 3 and quarterly x 2.</li> <li>Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</li> <li>Non-compliance with facility procedures may result in disciplinary action up to and including termination.</li> </ul> <p>Completion Date: 12/4/2015</p>		

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	<p>NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure all of the facility's smoke detectors are maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method.                  (2) Manufacturer's calibrated sensitivity test instrument.                  (3) Listed control equipment arranged for the purpose.                  (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable</p>	K 0052	<p><b>K 052 NFPA 101 Life Safety Code Standard</b> It is the practice of this facility to ensure the 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. However, based on the alleged deficient practice the following has been implemented:</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> · The smoke detector sensitivity testing was completed on October 28th, 2015 but the Maintenance Supervisor did not have the record. The record was forwarded to the Maintenance Supervisor by Vanguard Alarm Services on November 13th, 2015. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b> · All residents have the potential to be affected by the alleged deficient practice. · The Maintenance Supervisor will request copies from all 3rd party vendors who check the fire alarm system including the sensitivity testing on</p>	12/04/2015			

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	<p>sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor and Environmental Supervisor on 11/12/15 from 9:00 a.m. to 10:00 a.m. the smoke detector sensitivity testing was past due. The documentation titled, "Smoke Detector Sensitivity " by Integrated Electronics System showed the last sensitivity testing was completed on 04/29/13. Based on interview at the time</p>		<p>the smoke detectors. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</b></p> <ul style="list-style-type: none"> <li>· The Maintenance Supervisor will request copies from all 3rd party vendors who check the fire alarm system including the sensitivity testing on the smoke detectors and ensure they check again within the expected 2 year time frame.</li> <li>· The Maintenance Director/Designee will in-service Maintenance Assistant on the sensitivity tests by December 4th, 2015.</li> <li>· The Maintenance Director is in charge of program compliance</li> </ul> <p><b>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:</b></p> <ul style="list-style-type: none"> <li>· A CQI monitoring tool called fire alarm checks will be utilized weekly x 4, monthly x 3 and quarterly x 2.</li> <li>· Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</li> <li>· Non-compliance with facility procedures may result in disciplinary action up to and including termination.</li> </ul> <p><b>Completion date: 12/4/2015</b> <b>Reason for IDR is the paperwork verifying the sensitivity test was done within</b></p>				

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	of record review, the Maintenance Supervisor acknowledged the last smoke detector sensitivity testing was completed on 04/29/13.  3.1-19(b)		<b>2 years was not available at the time of the survey but has since been sent to the building and is on file here. A copy of the paperwork will be submitted with POC.</b>		