

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  12/02/2014
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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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K010000	<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: 12/02/14</p> <p>Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Thomas Forbes, Life Safety Code Specialist</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</p>	K010000	<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.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. This facility respectfully requests a revisit on or after January 1, 2015.</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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K010021 SS=D	<p>resident rooms. The facility has a capacity of 150 and had a census of 139 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/08/14.</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 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. 18.2.2.2.6 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 doors</p>	K010021	<b>K 021 NFPA 101 Life Safety</b>	01/01/2015

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	<p>serving hazardous areas such as a laundry was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Environmental supervisor on 12/2/14 at 11:03 am, the clean laundry room door and soiled laundry room door was held open by a device, folded paper, which would not allow the door to close automatically upon activation of the fire alarm system. Based on interview during the times of observation, the Maintenance Supervisor acknowledged the doors should not be propped open.</p> <p>3.1-19(b)</p>		<p><b>Code Standard</b></p> <p>It is the practice of this facility to ensure that all doors in an exit passageway, stairway, enclosure, horizontal exit, smoke barrier or hazardous areas enclosure are only held open using devices arranged to automatically close all such doors by zone or throughout the facility upon activation of the manual fire alarm system or the local smoke detectors or the automatic sprinkler system. 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></p> <p>The device that were propping open the corridor doors to the Laundry room have been removed. The device was removed on 12/2/2014.</p> <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>		

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			<ul style="list-style-type: none"> <li>· All staff that use the Laundry room have the potential to be affected by the alleged deficient practice.</li> <li>· All corridor doors were checked to ensure nothing is propping them open by Maintenance Director. The doors were checked prior to January 1st, 2015 to ensure they are not propped open.</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 corridor doors on a daily basis to ensure they are not propped open.</li> <li>· The Maintenance Director/Designee will in-service all managers to monitor corridor doors to ensure they are not propped open. In-service will be completed by 1/1/15.</li> <li>· The Maintenance Director is in charge of program compliance</li> </ul>	

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K010038 SS=E	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. 18.2.1 Based on observation and interview, the	K010038	<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 Corridor 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><b>Completion Date: 1/1/2015</b></p> <p><b>K 038 NFPA 101 Life Safety</b></p>	01/01/2015	

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	<p>facility failed to ensure the means of egress for 1 of 9 exits discharge paths was readily accessible at all times and free of all obstructions which could interfere with the use of the exit discharge path. This deficient practice could affect 24 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor and Environmental Supervisor on 12/02/2014 at 10:50 a.m., the exit egress corridor serving the service and 400 hall, identified on the facility evacuation diagram as an exit, was used for storing equipment and materials which were not in use:</p> <p>a. Four cardboard boxes of Christmas Trees on a cart; b. 14 mattress; c. 3 beds; d. A large piece of kitchen equipment.</p> <p>Upon interview at the time of observations, the Maintenance Supervisor stated that the area was used because of the lack of other storage areas in the facility.</p> <p>3.1-19(b)</p>		<p><b>Code Standard</b></p> <p>It is the practice of this facility to ensure all exits are readily accessible at all times. 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></p> <ul style="list-style-type: none"> <li>· The service hall was cleared of all mattresses, beds, kitchen equipment and Christmas decoration boxes on December 3, 2014.</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 residents have the potential to be affected by the alleged deficient practice.</li> <li>· All other service halls were checked to ensure the service halls were clear.</li> </ul>		

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			<p><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 service hall was cleared of all mattresses, beds, kitchen equipment and Christmas decoration boxes on December 3, 2014.</li> <li>· The service hall will be monitored by the Maintenance Director/Designee on an on-going basis to ensure it remains clear.</li> <li>· The Maintenance Director/Designee will in-service all department heads on not storing anything including but not limited to kitchen equipment, beds, mattresses or decorations by January 1, 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>	

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K010062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler heads in room 223 were maintained. This deficient practice could affect 2 residents.</p> <p>Findings include:</p>	K010062	<ul style="list-style-type: none"> <li>A CQI monitoring tool called Service Hallway Egress will be utilized weekly x 4 and every month 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: 1/1/2015</b></p> <p><b>K 062 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure the sprinkler system is continuously maintained and in reliable operating condition and are inspected and tested</p>	01/01/2015	

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	<p>Based on observations on 12/02/14 at 1:15 p.m. during a tour of the facility with the Environmental Supervisor, one sprinkler head escutcheons in the closet of room 223 was missing leaving a one and a half inch gap into the attic above. At the time of observation, the Environmental Supervisor acknowledged the missing escutcheon and ceiling gap into the attic above.</p> <p>3.1-19(b)</p>		<p>periodically. 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></p> <ul style="list-style-type: none"> <li>The sprinkler head escutcheon in room 223 was fixed to eliminate the gap on or before December 3, 2014 to ensure they latch into the frame.</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 residents have the potential to be affected by the alleged deficient practice.</li> <li>All sprinkler head escutcheons will be checked by maintenance staff on or before January 1, 2015 to ensure they are no gaps.</li> </ul>		

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			<p><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 sprinkler head escutcheon in room 223 was fixed to eliminate the gap on or before December 3, 2014 to ensure they latch into the frame.</li> <li>· All sprinkler head escutcheons will be monitored on an on-going basis by the Maintenance Director/Designee.</li> <li>· The Maintenance Director/Designee will in-service Maintenance Assistant on the sprinkler head escutcheons and preventing gaps by January 1, 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</li> </ul>	

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K010067 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 vented gas fireplaces was installed in accordance with Exception No. 2 to LSC Section 19.5.2.2. Exception No. 2 states fireplaces shall be used only in areas other than patient sleeping areas provided such areas are separated from patient sleeping spaces by construction having not less than 1 hour fire resistance rating</p>	K010067	<p>called Sprinkler Heads will be utilized weekly x 4, monthly x 3 and quarterly x 2.</p> <ul style="list-style-type: none"> <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: 1/1/2015</b></p> <p><b>K 067 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure all heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. However, based on the alleged deficient practice</p>	01/01/2015

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	<p>and such fireplaces comply with the provisions of 9.2.2. In addition, the fireplace shall be equipped with a fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and constructed of heat tempered glass or other approved material. This deficient practice could affect 15 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/02/14 at 12:26 p.m., the Maintenance Supervisor and the Environmental Supervisor acknowledged the gas burning fireplace located in the main entrance lobby was not separated from resident rooms 400, 402, 501, 503, and 100 through 105 by construction having at least one hour fire resistance rating. Based on telephone interview with the Maintenance Supervisor on 12/05/14 at 4:04 p.m., he was unable to confirm the fireplace enclosure guaranteed against breakage up to a temperature of 650 degrees Fahrenheit and was constructed of heat tempered glass or other approved material.</p> <p>3.1-19(b)</p>		<p>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></p> <ul style="list-style-type: none"> <li>The fireplace in the main lobby has been shut off and disabled from operation on or before January 1, 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 residents have the potential to be effected by the alleged deficient practice.</li> <li>The fireplace will be checked by maintenance staff on or before January 1, 2015 to ensure there is no heating element.</li> </ul> <p><b>What measures will be put into place or what systemic</b></p>		

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			<p><b>changes you will make to ensure that the deficient practice does not recur</b></p> <ul style="list-style-type: none"> <li>· The fireplace in the main lobby has been shut off and disabled from operation on or before January 1, 2015.</li> <li>· All fireplaces will be checked to ensure there is no heating element by the Maintenance Director/Designee on or before January 1, 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 Fireplaces will be utilized 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> </ul>	

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 6 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p>	K010130	<p>• Non-compliance with facility procedures may result in disciplinary action up to and including termination.</p> <p><b>Completion date: 1/1/2015</b></p> <p><b>K 130 NFPA 101 Life Safety Code Standard</b></p> <p>It is the practice of this facility to ensure all penetrations in the fire barrier are filled with a material that is capable of maintaining the fire resistance of the fire barrier. 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></p> <p>• The unsealed penetration in the fire barrier wall by rooms</p>	01/01/2015

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  12/02/2014	
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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	<p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect 32 residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor and Environmental Supervisor on 12/02/14 at 1:00 p.m., there was an unsealed penetration measuring one and one fourth inch around electric wires above the ceiling tile at the fire doors in the 200 hall by room 223. At the time of observation, the Maintenance Supervisor confirmed the 200 hall was a fire barrier wall and acknowledged the unsealed fire wall penetration measured one and one fourth inch.</p>		<p>223 on the 200 hall was fixed and sealed on December 3, 2014.</p> <ul style="list-style-type: none"> <li>· The rolling fire door was inspected on December 16, 2015 by Vanguard Systems Inc.</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 residents have the potential to be effected by the alleged deficient practice.</li> <li>· All rolling fire doors were checked to ensure they were reviewed by Vanguard within the last year.</li> </ul> <p><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>· All fire barriers will be monitored by maintenance staff on an on-going basis and after any work completed by any outside contractors.</li> </ul>				

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	<p>3.1-19(b)</p> <p>2. Based on observation, record review and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. 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 any resident in the main dining room which usually seats 40 residents or more.</p> <p>Findings include:</p> <p>Based on observation and record review with the Environmental Supervisor and the Maintenance Supervisor on 12/02/14 at 12:12 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room that did not have an annual inspection. The rolling fire door was not in a corridor wall. Based on interview with the Maintenance Supervisor at the time of</p>		<ul style="list-style-type: none"> <li>· The rolling fire door inspection will be scheduled on an annual basis.</li> <li>· The Maintenance Supervisor will in-service maintenance assistant on inspecting fire barriers and scheduling annual rolling fire door inspections. In-servicing will be completed on or before 1/1/2015.</li> <li>· Maintenance Director is responsible for 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 Barriers 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</li> </ul>				

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	observation, the rolling fire door did not receive an annual inspection. The last inspection was conducted on by Integrated Electronics on 11/14/13.  3.1-19(b)				termination.  Completion date: 1/1/2015		