STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155828	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF FORT WAYNE, THE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

(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	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). Survey Date: 04/05/16 Facility Number: 012931 Provider Number: 155828 AIM Number: 201278730 At this Life Safety Code survey, The Heritage of Fort Wayne was found not in compliance with Requirements for Participation 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. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridors with hard wired smoke detectors in all resident rooms. The facility has a capacity of 84 and had a census of 73 at the time of this visit.	K 0000		

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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	All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review on 04/08/16 - DA			
K 0025 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 2 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient	K 0025	All smoke walls will be inspected to ensure all unsealed penetrations are located. All residents have the potential to be affected by the lack of sealed penetrations to smoke barrier walls. All penetrations will be sealed and the maintenance staff in-serviced regarding proper sealing of all pipe sleeves and holes in order to maintain a smoke barrier. All pipe sleeves and holes in the Rehab/MC smoke wall, the Rehab/MC by Wurley, the Crofton smoke wall by the Won-Door, and the Crofton smoke wall by Milk-N-Honey will be sealed. All smoke barrier walls will be monitored quarterly, to ensue all sleeves and holes are sealed to prevent smoke penetration. **(Attachment A)**	04/28/2016

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	practice affects all residents. Findings include: Based on observations during a tour of the facility with Administrator and the Maintenance Supervisor on 04/05/16 between 12:00 p.m. and 1:00 p.m., the following smoke walls had unsealed penetrations: a) In the Rehab/MC smoke wall above the ceiling tiles by the Chadwick smoke doors there were five unsealed four inch pipe sleeves containing wires and two unsealed two inch holes. b) In the Rehab/MC smoke wall above the ceiling tiles by the Wurley smoke doors there were two unsealed four inch pipe sleeves containing wires. c) In the Crofton smoke wall above the ceiling tiles by the Won-Door smoke door there were two unsealed inch hole around wires. d) In the Crofton Smoke wall above the ceiling tiles by the Milk-n-Honey smoke door there were four unsealed inch holes around wires. Based on interview at the time of observation, the Maintenance Supervisor confirmed and provided the measurements of the penetrations. 3.1-19(b)			

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K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.THER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure penetrations in 2 of 2 fire barrier walls were maintained to ensure the fire resistance of the barrier. LSC 18.1.1.3 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: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the	K 0130	**1.** All fire barrier walls will be inspected to ensure all unsealed penetrations are located in the fire walls. All residents have the potential to be affected by the lack of sealed penetrations to fire walls. All maintenance staff will be in-serviced regarding tag K0130 and proper seals for all fire barrier walls to maintain a fire wall. All pipe sleeves will be sealed at the fire wall that separates Rehab from Residential Living as well as the pipe sleeves that separates HealthCare from Residental Living This includes being filled with a material that is capable of maintaining the fire resistance of the fire barrier and designed for the specific purpose, as well as being properly set. All fire barrier walls will be monitored quarterly to ensure all pipes, sleeves, and holes are sealed and set to maintain the fire wall. **(Attachment B) 2.** All 4 boilers will be inspected by the Sate Fire Marshall's Office, Division of Boilers & Pressure Vessels and an inspection	04/28/2016

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	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: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice affects all residents in the facility. Findings include: Based on observation during a tour of the facility with the Administrator and the Maintenance Supervisor on 04/05/16 at 12:30 p.m. and 12:45 p.m., the following fire walls had unsealed penetrations. a) There were five unsealed two inch pipe sleeves containing wires through the fire wall that separates rehabilitation from residential living. b) There were eight unsealed two inch pipe sleeves containing wires through the fire wall that separates health care from residential living. Based on interview at the time of observation, the Maintenance Supervisor confirmed the wall was a fire barrier and provided measurements of the penetration.		certificate obtained to ensure the boilers are in safe operating condition. All residents have the potential to be affected by the boilers not being inspected. All boilers are scheduled to be inspected by the State Fire Marshall's Office. **(Attachment C)** All maintenance staff have been in-serviced regarding proper safety inspections and tags for boilers. All boilers will be monitored quarterly to ensure inspection tags are on all boilers and are up-to-date. **(Attachment D)**	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 4 of 4 boilers had a current inspection certificate to ensure the boilers were in safe operating condition. NFPA 101, in 18.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice affect all residents Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor and Administrator on 04/05/16 at 11:00 a.m., the four boilers servicing the facility lacked a Certificate of Inspection. Based on an interview at the time of observation, the Maintenance Supervisor stated the four boilers have not been inspected. 3.1-19(b)			
K 0144 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) 1. Based on observation and interview,	K 0144	**1** A meeting with engineers from Innovative Control System (ICS)	04/28/2016

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	the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor and the Administrator on 04/05/16 during a tour of the facility at 10:50 a.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview at the time of observation, the Maintenance Supervisor stated there was no remote E-stop for the		and Primary Engineering was held to discuss solutions regarding a remote manual stop for the generator. All residents have the potential to be affected by the deficient practice A location for the remote manual stop was located where it was to be installed during the construction of the building. All staff will be in-serviced regarding the requirement for the provision of shutting down the engine at the generator from a remote location. The remote manual stop for the generator will be tested quarterly to ensure the generator can be shut down from a remote location. **(Attachment E)** **2** A meeting with engineers from Innovative Control Systems (ICS) and Primary engineering was held to discuss solutions regarding an annunciator for the generator. All residents have the potential be affected by the deficient practice. A location for the annunciator was found where it was to be installed during construction of the building. All staff will be in-serviced regarding the panel for the emergency generator with an alarm annunciator in a location readily observed by personnel at a staffed nurses station. The annunciator will be monitored quarterly to ensure it indicates alarm conditions of the emergency or auxiliary power source when any of the conditions in 3-4.1.1.5(a)and (b) occur. **(Attachment F)**	

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	generator. 3-1.19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature.			

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	4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Over-crank (failed to start). 6. Over-speed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants. Findings include: Based on an observation during a tour of the facility with Maintenance Supervisor on 04/05/16 at 1:10 p.m., the emergency generator did not have a working remote annunciator panel. Based on an interview at the time observation, the Maintenance Supervisor stated there was a panel in Crofften B wing that might be for the generator but the panel was never hooked up and was not working. 3-1.19(b)			