

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

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: 03/17/14</p> <p>Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire</p>	K010000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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.

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

	<p>alarm system with smoke detection in corridors and in areas open to the corridors with battery operated smoke detector in the resident rooms. The facility has a capacity of 149 and had a census of 116 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, except a shed used for general storage and a garage used for maintenance storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/20/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
--	---	--	--	--

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 03/17/2014	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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			
K010029 SS=E	<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 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 1 of 2 corridor doors to the laundry room and 1 of 1 corridor doors to the biohazardous waste room, both a hazardous areas, would latch into the door frame. This deficient practice could affect visitors, staff and 20 or more residents in the main dining room should they be evacuated through the service hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and Maintenance Assistant on 03/17/14 from 2:35 p.m. to 2:40 p.m., the corridor door entering the soiled linen area of the laundry room and the corridor door to the biohazardous waste room did self close, but failed to latch into the door frame. This was</p>	K010029	<p>K0029 - The facility will ensure both the laundry room door and biohazard waste room door latches with the door frame. The self closer on the laundry room door was replaced to ensure the door would latch. The closer to the biohazard door was adjusted to ensure it will latch to the door frame. Maintenance has completed a thorough review of all areas in the facility to ensure there are no similar additional areas out of compliance. Maintenance will add this visual check and follow up to their monthly building review for compliance. Results of the monthly check will be brought to the facility monthly QA committee for review and follow up for a minimum of 3 months and until the facility sustains a consistent pattern of compliance with a subsequent plan developed and implemented as necessary.</p>	03/31/2014			

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
	confirmed by the Maintenance Director at the time of observations. 3.1-19(b)			

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 03/17/2014	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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			
K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report" and the "Emergency Fire/Evacuation Drill" documentation with the Maintenance Director and the Maintenance Assistant on 03/17/14 at 11:20 a.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p>The facility will ensure the type of fire drill and location will be included on our fire drill forms. Changes to the forms were made on 3/21 and have been implemented. Maintenance will document the fire drill location and type of fire going forward. Fire drill documentation will be monitored by the facility monthly QA committee for review and follow up for a minimum of three months and until the facility has sustains a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.</p>	03/21/2014			

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 11 sprinkler heads in the Bed and Breakfast (B&B) dining area were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any of the 18 residents in the B&B unit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant on 03/17/14 at 1:10 p.m., the B&B dining room area had two sprinkler heads located 32 inches apart above the nurses' station. Measurements were provided by the</p>	K010056	The facility will ensure that sprinkler heads are separated by at least six feet. The Fire and security company will make necessary repairs to the sprinkler system in Bed and Breakfast to ensure compliance. Maintenance staff has completed a thorough review of all areas in the facility to ensure there are no additional similar areas out of compliance. After changes are made to the two sprinkler heads in Bed and Breakfast, no monitoring will be required, facility will be in compliance.	04/04/2014
-----------------	--	---------	--	------------

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
	Maintenance Director at the time of observation. 3.1-19(b)			

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

K010067 SS=C	<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. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 damper inspection forms included all necessary information in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the invoice from Extinguisher Co. No. 1 dated 04/08/13 with the Maintenance Director and the Maintenance Assistant on 03/17/14 at 3:15 p.m., the documentation stated 44 dampers were inspected. Based on an interview with the Maintenance Director</p>	K010067	The facility will ensure the fire extinguisher company inspects all dampers at least every four years. Maintenance supervisor labeled/identified all dampers in the facility. The fire extinguisher company will identify and inspect all dampers facility wide by 4/11/14. Results of the monitoring will be brought to the QA committee for review and follow up.	04/11/2014
-----------------	---	---------	---	------------

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

	<p>after he spoke with a representative from Extinguisher Co. No. 1, the company was unable to provide documentation that included the location of each damper and a record of discrepancies found.</p> <p>3.1-19(b)</p>			
--	--	--	--	--

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 03/17/2014	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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			
K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure the baffle filters in 1 of 1 kitchen exhaust systems were installed correctly. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 3-2.3 requires grease filters shall be tight fitting and firmly held in place. This deficient practice could affect kitchen staff and 20 or more residents in the main dining room.</p> <p>Finding include:</p> <p>Based on observation with the Maintenance Director on 03/17/14 at 2:42 p.m., the smaller baffle filters at each end of the kitchen hood were missing pieces and falling apart leaving spaces between the filters. At the time of observation, the Maintenance Director stated he had already replaced two full sized baffle filters for the same reason.</p> <p>3.1-19 (b)</p>	K010069	The facility will ensure the baffle filters in the kitchen hoods are all replaced, leaving no spaces between the filters. Maintenance has ordered and will replace all eight filters in the kitchen. Dietary will ensure that the filters are cleaned monthly. Results of the monthly checks will be brought to the facility monthly QA committee for review and follow up for a minimum of six months and until the facility sustains a consistant patterns of compliance with a subsequent plan developed and implemented as necessary.	04/04/2014			

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 03/17/2014	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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			
K010143 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to provided posted signs indicating transferring is occurring in 1 of 1 oxygen transferring locations. This deficient practice could affect 1 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Assistant Maintenance Director on 03/17/14 at 12:55 p.m., the oxygen transferring room lacked the required sign stating transferring is occurring. At the time of observation, the Maintenance Director confirmed the oxygen room was used for oxygen transferring and the door lacked the proper signage.</p>	K010143	The facility will ensure that a sign will be utilized by staff when transferring of oxygen is occurring. Maintenance staff has completed a thorough review to ensure there are no additional similar areas out of compliance. Maintenance staff will monitor the oxygen rooms to ensure the staff are utilizing the signs. This monitoring will occur 3x/week for a month, 1x/week for a month and monthly going forward to ensure compliance. Results of monitoring will be brought to the facility QA committe monthly for a minimum of six months and until the facility has sustained a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/24/2014			

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 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

	3.1-19(b)			
--	-----------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
K020000	<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: 03/17/14</p> <p>Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>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.</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</p>			K020000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

	<p>corridors and in areas open to the corridors with battery operated smoke detectors in the resident rooms. The facility has a capacity of 149 and had a census of 116 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, except a shed used for general storage and a garage used for maintenance storage.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED 03/17/2014	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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			
K020050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Fire Drill Report" and the "Emergency Fire/Evacuation Drill" documentation with the Maintenance Director and the Maintenance Assistant on 03/17/14 at 11:20 a.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K020050	The facility will ensure the type of fire drill and location will be included on our fire drill forms. Changes to the forms were made on 3/21 and have been implemented. Maintenance will document the fire drill location and type of fire going forward. Fire drill documentation will be monitored by the facility monthly QA committee for review and follow up for a minimum of three months and until the facility has sustains a consistant pattern of compliance with a subsequent plan developed and implemented as necessary.	03/21/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

K020067 SS=C	<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 record review and interview, the facility failed to ensure 1 of 1 damper inspection forms included all necessary information in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the invoice from Extinguisher Co. No. 1 dated 04/08/13 with the Maintenance Director and the Maintenance Assistant on 03/17/14 at 3:15 p.m., the documentation stated 44 dampers were inspected. Based on an interview with the Maintenance Director</p>	K020067	The facility will ensure the fire extinguisher company inspects all dampers at least every four years. Maintenance supervisor labeled/identified all dampers in the facility. The fire extinguisher company will identify and inspect all dampers facility wide by 4/11/14. Results of the monitoring will be brought to the QA committee for review and follow up.	04/11/2014
-----------------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR 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
--------------------	--	---------------	---	----------------------

	<p>after he spoke with a representative from Extinguisher Co. No. 1, the company was unable to provide documentation that included the location of each damper and a record of discrepancies found.</p> <p>3.1-19(b)</p>			
--	--	--	--	--