STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155654	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN 46809

(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
K0000	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: 01/23/13 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Englewood Health & 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111)	K0000	***The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.***	

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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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, areas open to the corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 67 and had a census of 60 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance shed used for the storage of beds. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/30/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 1 or possibly 2 residents in the Beauty Shop. Findings include: Based on an observation with the Maintenance Director on 01/23/13 at 12:25 p.m., one of twenty four ceiling penetrations in the Beauty Shop electrical room was sealed with expandable foam then partially covered with fire caulk. At the time of observation,	K0025	1. Facility corrected and replaced beauty shop sprinkler head with appropriate fire caulking. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Alleged deficient practice has been corrected for all fire sprinkler heads. 4. Maintenance Director shall observe fire sprinkler heads once per week for four weeks; then monthly thereafter. Concerns shall be forwarded to Quality Assurance Committee. 5. Date certain: February 22, 2013.	02/22/2013

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	the Maintenance Director acknowledged the expandable foam needed to be removed. 3.1-19(b)			

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K0044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any of the residents in the main dining room with a seating capacity of 36. Findings include: Based on observation with the Maintenance Director on 01/23/13 at 12:21 p.m., the fire doors entering the activity hall from the main dining room failed to latch into the frame leaving a	K0044	1. Maintenance completed on door to ensure completely latches into the frame. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Alleged deficient practice has been corrected for all fire doors. 4. Maintenance Director shall monitor once per week for four weeks; then monthly thereafter. Concerns shall be forwarded to Quality Assurance Committee. 5. Date certain: February 22, 2013.	02/22/2013

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	one half inch gap between the door and the door frame. The measurement was provided by the Maintenance Director. Based on an interview with the Maintenance Director at the time of observation, these doors were confirmed to be fire doors. 3.1-19(b)			

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K0050 SS=F	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 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Fire Drill Report" with the Maintenance Director on 01/23/13 at 11:15 a.m., there was no record of a second shift fire drill for the third quarter of 2012. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b)	K0050	1. Corrective action cannot be taken as the alleged deficiency occurred in the past. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Maintenance Director received in-service on 10-31-12 related to fire drill completion in accordance to NFPA regulations. 4. Maintenance Director shall report to Administrator the dates and shifts of that quarter's fire drills at the beginning of each quarter. Administrator to monitor monthly for compliance. Concerns shall be forwarded to Quality Assurance Committee. 5. Date certain: February 22, 2013.	02/22/2013

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	3.1-51(c)			