

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE FORT WAYNE, IN 46805
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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: 08/27/13</p> <p>Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Life Care Center of Fort Wayne 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.</p> <p>This one story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</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. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 9/10/2013.</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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	<p>capacity of 125 and had a census of 58 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 maintenance office/workshop/storage building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/29/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure the doors protecting corridor opening in 1 of 2 dining rooms and 1 of 1 central supply rooms were smoke resistive. This deficient practice could affect at least 15 residents in the Beecher dining room and 4 residents in the Social Services office lounge.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance on 08/27/13 from 1:00 p.m. to 2:00 p.m., there was a one half inch hole in the corridor door on the north side of the Beecher dining room and there was a one fourth inch hole in the Central Supply room corridor door across from</p>	K010018	<p>K – 018 It is the policy of this facility to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The dining room door and central supply were repaired and made to be smoke resistive. How will other residents having the</p>	09/10/2013			

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	<p>the Social Services office lounge. Measurements were provided by the Director of Maintenance at the time of observations.</p> <p>3.1-19(b)</p>		<p>potential be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other doors were identified as to not meeting this requirement. Doors protecting a corridor opening have the potential to be at risk. All doors protecting a corridor opening were inspected to ensure requirement with this practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director will be re-educated on this requirement by the Executive Director. The Maintenance Director and/or designee will monitor compliance with this requirement by completing routine rounds as part of the facility's Preventive Maintenance Program logged within TELs. The Maintenance Director inspect facility doors weekly x4 weeks then monthly x4 months and then quarterly or until 100% compliance is achieved. The doors will be inspected annually as part of the facility's preventive maintenance program (TELs). The Maintenance Director and/or designee will be responsible for those inspections. How will the corrective action(s) will be monitored to ensure the deficient practice will be not recur, i.e., what quality assurance program will be put into place; Monitoring of doors protecting a corridor</p>	

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			opening will be completed by the Maintenance Director and/or designee. Any non-compliance with this requirement will be addressed monthly at the facility's PI meeting. By what date the systemic changes will completed - 9/10/2013		

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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 the doors entering 1 of 1 kitchens would self close and positively latch into the door frame. This deficient practice could affect residents evacuated through the service hall from the main dining room which could seat at least 15 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 08/27/13 at 1:45 p.m., the door entering the kitchen from the service hall was equipped with only a dead bolt. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>	K010029	<p>K – 029 It is the policy of this facility to have 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The doors entering the kitchen have been repaired to ensure they self close and positively latch into the door frame. How will other residents having the potential be affected</p>	09/10/2013	

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			by the same deficient practice will be identified and what corrective action(s) will be taken; No other doors were identified as to not meeting this requirement. All doors have the potential to be at risk of not meeting this requirement. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director will be re-educated on this requirement by the Executive Director. The Maintenance Director and/or designee will monitor compliance with this requirement by completing routine rounds as part of the facility's Preventive Maintenance Program logged within TELs. The Maintenance Director inspect facility doors weekly x4 weeks then monthly x4 months and then quarterly or until 100% compliance is achieved. The doors will be inspected annually as part of the facility's preventive maintenance program (TELs). The Maintenance Director and/or designee will be responsible for those inspections. How will the corrective action(s) will be monitored to ensure the deficient practice will be not recur, i.e., what quality assurance program will be put into place; Monitoring of doors protecting a corridor opening will be completed by the Maintenance Director and/or designee. Any non-compliance with this requirement will be	

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			addressed monthly at the facility's PI meeting. By what date the systemic changes will completed - 9/10/2013	