STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155756	A. BUILDING -- B. WING	11/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/21/22 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 At this Emergency Preparedness survey, Coventry Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 150 and had a census of 110 at the time of this survey. Quality Review completed on 11/23/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/21/22 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 At this Life Safety Code survey, Coventry Meadows was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Hardy	Executive Director	12/09/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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) 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 resident rooms. The facility has a capacity of 150 and had a census of 110 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/23/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 1 exit discharge gates were free of impediments to full instant use in the case of fire or another emergency. This deficient practice could affect 25 residents using the 100-hall exit during an emergency. Findings include:	K 0211	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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be	11/23/2022

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	Based on observations with the Maintenance Director and Administrator on 11/21/22 at 11:15 a.m., there was an exit gate from the 100-hall courtyard out to the common way. When the gate was tested it would not open due to the gate was zip-tied shut. Based on interview at the time of observation, the Maintenance Director stated the wind was blowing the gate open and it was zip-tied until a contractor fixed the gate. The Maintenance Director did remove the zip-tie. The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident, this facility respectfully requests a desk review in lieu of a post survey revisit on or before December 11, 2022. It is the practice of this provider to maintain means of egress free of all obstructions to full use in case of emergency continuously. 1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents were found to be affected from the alleged deficient practice. The exit discharge gate was corrected upon identification and the tie was removed from the gate. The gate was fixed on November 23,2022 by Integrated Electronics of Indiana. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction will be taken: All staff will have been in serviced on the policy that all means of egress must be maintained without obstructions and in full use in case of emergency. 3. 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 audit the means of egress using	

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			the Egress Audit Tool weekly x 4 weeks, monthly x 3 months and quarterly thereafter to ensure that all means of egress are maintained and are free from obstructions to ensure full use in case of emergency. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: All employees have been in serviced on the importance of maintaining all egresses obstruction free to full use and free of impediments all the time. The Maintenance Director will audit the means of egress to ensure compliance is maintained weekly x 4 weeks, monthly x 3 months, and quarterly thereafter. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director. If the audits show below 100% compliance, an action plan will be developed to ensure compliance. 5. What date the systematic changes for each deficiency will be completed: The above deficiency was corrected 11/23/2022.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable			

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	patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects four residents. Findings include: Based on observations with the Maintenance Director and Administrator on 11/21/22 between 10:00 a.m. and 12:00 p.m., power-strips in room 400 and 509 were in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed power-strips were in use in resident care areas and did not meet 1363A or 60601-1.	K 0920	K920 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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident, this facility respectfully requests a desk review in lieu of a post survey revisit on or before December 11, 2022. 1. What corrective action(s) will be accomplished for those residents	11/23/2022

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	The findings were reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		found to have been affected by the deficient practice: No residents have been affected by the alleged deficient practice. All resident care areas have been audited and power strips not meeting the required UL rating of 1363A or 60601-1 have been removed and will be replaced with power strips that meet the required UL rating of 1363A or 60601-1. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All resident care areas have been audited to ensure that power strips being used meet the required UL rating of 1363A or 60601-1 using the Power Strip Audit Tool. Power strips not meeting the required UL rating of 1363A or 60601-1 have been removed and will be replaced. All staff have been in serviced on the proper power strip to be used in a resident care area. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All employees have been educated by the Executive Director and Maintenance Director of the proper power strip required to be utilized in the resident care area. 4. How the corrective action will be monitored to ensure the deficient	

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			practice will not recur: The Power Strip Audit tool will be utilized by the Executive Director/Designee or Maintenance Director/Designee weekly x 4 weeks, monthly x 3 months and quarterly thereafter to ensure 100% compliance is achieved. The results of these audits will be reviewed by the QAPI Committee overseen by the Executive Director. If the threshold is not achieved, an action plan will be developed to ensure compliance. 5. What date the systemic changed for each deficiency will be completed: November 23, 2022.	