| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) MULTIPLE CONSTRUCTION   |       | (X3) DATE SURVEY |  |           |            |
|--|---|--|-------|------------------|--|-----------|------------|
| AND PLAN   | OF CORRECTION   | IDENTIFICATION NUMBER  |       | ILDING           | <del></del>  | COMPLETED |            |
|  |   | 155656   | B. WI | B. WING          |  | 01/10/    | 2023       |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |       |                  | ADDRESS, CITY, STATE, ZIP COD<br>ORTHGATE BLVD   |           |            |
| CANTER   | BURY NURSING A  | ND REHABILITATION CENTER   | _     | FORT V           | VAYNE, IN 46835  |           |            |
| (X4) ID  |   | STATEMENT OF DEFICIENCIE   |       | ID               | PROVIDER'S PLAN OF CORRECTION  |           | (X5)       |
| PREFIX<br>TAG  |   | CY MUST BE PRECEDED BY FULL  |       | PREFIX           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup><br>DEFICIENCY) | ΓE        | COMPLETION |
| E 0000   | REGULATORY OR   | LSC IDENTIFYING INFORMATION  |       | TAG              |  |           | DATE       |
| _ 0000   |   |  |       |                  |  |           |            |
| Bldg   | conducted by the In accordance with 42                        |  | E 00  | 000              | This facility is requesting pape compliance  | r         |            |
|  | Survey Date: 01/10  | 0/23   |       |                  |  |           |            |
|  |   | 55656<br>90930<br>Preparedness survey,<br>and Rehabilitation Center was  |       |                  |  |           |            |
|  | Medicaid Participat<br>CFR 483.73. The fa                     | rements for Medicare and ing Providers and Suppliers, 42 scility has a capacity of 142 and at the time of this survey. |       |                  |  |           |            |
| K 0000   |   |  |       |                  |  |           | '          |
|  |   |  |       |                  |  |           |            |
| Bldg. 01   | Licensure Survey w  | Recertification and State as conducted by the Indiana th in accordance with 42 CFR                                     | K 00  | 000              | This facility is requesting pape compliance  | r         |            |
|  | Survey Date: 01/10  | 0/23   |       |                  |  |           |            |
|  | Facility Number: 00<br>Provider Number: 1<br>AIM Number: 1002 | 55656  |       |                  |  |           |            |
|  | Nursing and Rehabi  | Code survey, Canterbury  Ilitation Center was found not  Requirements for Participation                                |       |                  |  |           |            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Meeta Anand Executive Director 01/23/2023

Any defiency statement 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 disclodays 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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| <u> </u>                   |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY   |             |  |            |  |
|----------------------------|--|---|-------------|--|------------|--|
| AND PLAN                   | OF CORRECTION  | IDENTIFICATION NUMBER   | A. BUILDING | 01   | COMPLETED  |  |
|                            |  | 155656  | B. WING     |  | 01/10/2023 |  |
|                            | PROVIDER OR SUPPLIER   | ND REHABILITATION CENTER  | 2827        | ET ADDRESS, CITY, STATE, ZIP COD<br>Y NORTHGATE BLVD<br>IT WAYNE, IN 46835                             |            |  |
| (X4) ID                    | SUMMARY  | STATEMENT OF DEFICIENCIE  | ID          | DESCRIPTION OF STREET  | (X5)       |  |
| PREFIX                     |  | CY MUST BE PRECEDED BY FULL   | PREFIX      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  | COMPLETION |  |
| TAG                        | REGULATORY OR  | LSC IDENTIFYING INFORMATION   | TAG         | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | DATE       |  |
|                            | Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation office occupancy with the control of the Care Occupancy with the control of the Care Occupancy with the Care Occ | aid, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2.  ity with a partial second-story as separated by a two hour as determined to be of Type V and was fully sprinklered. The arm system with smoke ridors, areas open to the y-operated smoke detectors in The facility is fully protected diesel powered generator. The ty of 142 and had a census of s survey.  idents have customary access the facility had a detached awn equipment, maintenance plies that was not sprinklered. |             |  |            |  |
| K 0211<br>SS=E<br>Bldg. 01 | NFPA 101 Means of Egress - Means of Egress - Aisles, passagewa discharges, exit lo in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation   | General ays, corridors, exit cations, and accesses are chapter 7, and the means accussly maintained free of full use in case of s modified by 18/19.2.2  110.1 on and interview, the facility   | K 0211      | Based on observation and   | 01/25/2023 |  |
|                            | were able to open fr   | f 3 exit doors in the kitchen from the egress side. LSC s complying with 7.2.1 shall be   |             | interview, the facility failed to<br>ensure 1 of 3 exit doors in the<br>kitchen were able to open from | <u>ie</u>  |  |

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Event ID:

1LSZ21

Facility ID: 000275

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| STATEMEN  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA         | A (X2) M |         | (X2) MULTIPLE CONSTRUCTION   |           | ONSTRUCTION | (X3) DATE SURVEY |  |
|-----------|----------------------|------------------------------------|----------|---------|--|-----------|-------------|------------------|--|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER              | A. BU    | JILDING | 01   | COMPLETED |             |                  |  |
|           |                      | 155656                             | B. W     | ING     |  | 01/10/    | 2023        |                  |  |
|           |                      |                                    |          | CTREET  | ADDRESS SITY STATE TIP SOD   |           |             |                  |  |
| NAME OF F | PROVIDER OR SUPPLIE  | R                                  |          |         | ADDRESS, CITY, STATE, ZIP COD  |           |             |                  |  |
| CANTED    |                      | AND DELIABILITATION CENTED         |          |         | ORTHGATE BLVD  |           |             |                  |  |
| CANTER    | BURY NURSING P       | AND REHABILITATION CENTER          |          | FURIV   | WAYNE, IN 46835  |           |             |                  |  |
| (X4) ID   | SUMMARY              | STATEMENT OF DEFICIENCIE           |          | ID      | PROVIDER'S PLAN OF CORRECTION  |           | (X5)        |                  |  |
| PREFIX    | (EACH DEFICIEN       | NCY MUST BE PRECEDED BY FULL       |          | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE        | COMPLETION  |                  |  |
| TAG       | REGULATORY OF        | R LSC IDENTIFYING INFORMATION      |          | TAG     | DEFICIENCY)  |           | DATE        |                  |  |
|           | permitted. 7.2.1.5.1 | Door leaves shall be arranged      |          |         | the egress side.   |           |             |                  |  |
|           | to be opened readil  | y from the egress side             |          |         | What corrective action will b  | е         |             |                  |  |
|           | whenever the build   | ing is occupied. This deficient    |          |         | accomplished for those   |           |             |                  |  |
|           | practice could staff | in the kitchen.                    |          |         | residents found to have been   | n         |             |                  |  |
|           |                      |                                    |          |         | affected by the deficient  |           |             |                  |  |
|           | Findings include:    |                                    |          |         | practice   |           |             |                  |  |
|           |                      |                                    |          |         | No residents were found to ha  | ive       |             |                  |  |
|           | Based on observation | on with the Maintenance            |          |         | been affected by the deficient   |           |             |                  |  |
|           | Director on 01/10/2  | 23 at 10:48 a.m., the kitchen exit |          |         | practice. The deficient practice                                       |           |             |                  |  |
|           | door to the dining r | room did not open when tested      |          |         | affected the kitchen staff and   |           |             |                  |  |
|           |                      | or handle. Based on interview      |          |         | immediately addressed by   |           |             |                  |  |
|           | at the time of obser | vation, a kitchen worker stated    |          |         | replacing the broken door har  | dle       |             |                  |  |
|           | the handle was not   | working properly and had to        |          |         | allowing the door to open eas  |           |             |                  |  |
|           | jiggle the door hand | dle and pull up to open the        |          |         | How other residents having   | •         |             |                  |  |
|           | door. The Mainten    | ance Director agreed the door      |          |         | potential to be affected by th   |           |             |                  |  |
|           | would not properly   | open and stated the handle         |          |         | same deficient practice will I   |           |             |                  |  |
|           | needs to be replace  | d.                                 |          |         | identified and what corrective   |           |             |                  |  |
|           | _                    |                                    |          |         | action(S) will be taken  |           |             |                  |  |
|           | This finding was re  | eviewed with the Administrator     |          |         | All residents and kitchen staff  |           |             |                  |  |
|           | and Maintenance D    | Director during the exit           |          |         | have the potential to be affect  |           |             |                  |  |
|           | conference.          | -                                  |          |         | by this deficient practice.  |           |             |                  |  |
|           |                      |                                    |          |         | This deficient practice was  |           |             |                  |  |
|           | 3.1-19(b).           |                                    |          |         | immediately addressed by   |           |             |                  |  |
|           |                      |                                    |          |         | ensuring all the three exits in  | the       |             |                  |  |
|           |                      |                                    |          |         | kitchen were able to open fror   |           |             |                  |  |
|           |                      |                                    |          |         | egress side.   |           |             |                  |  |
|           |                      |                                    |          |         | What measures will be put in   | 1         |             |                  |  |
|           |                      |                                    |          |         | place and what systemic  |           |             |                  |  |
|           |                      |                                    |          |         | changes will be made to  |           |             |                  |  |
|           |                      |                                    |          |         | ensure that the deficient  |           |             |                  |  |
|           |                      |                                    |          |         | practice does not recur  |           |             |                  |  |
|           |                      |                                    |          |         | All kitchen staff and managers   | s will    |             |                  |  |
|           |                      |                                    |          |         | be educated regarding the wo   | rk        |             |                  |  |
|           |                      |                                    |          |         | order process when somethin  | g is      |             |                  |  |
|           |                      |                                    |          |         | not working or out of service to                                       | 0         |             |                  |  |
|           |                      |                                    |          |         | ensure immediate resolution of   | of the    |             |                  |  |
|           |                      |                                    |          |         | issue.   |           |             |                  |  |
|           |                      |                                    |          |         |  |           |             |                  |  |
|           |                      |                                    |          |         | How the corrective action(s)   | will      |             |                  |  |
|           |                      |                                    |          |         | be monitored to ensure the   |           |             |                  |  |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2023 FORM APPROVED OMB NO. 0938-039

|                            | T OF DEFICIENCIES OF CORRECTION   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155656  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  01   | (X3) DATE SURVEY COMPLETED 01/10/2023   |
|----------------------------|---|--|--|---|---|
|                            | ROVIDER OR SUPPLIER<br>BURY NURSING A   | ND REHABILITATION CENTER   | 2827 N                                     | ADDRESS, CITY, STATE, ZIP COD<br>ORTHGATE BLVD<br>WAYNE, IN 46835   |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION                                       | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | PRIATE COMPLETION DATE  |
| K 0222<br>SS=E<br>Bldg. 01 | be equipped with requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lockinical security neused, only one locking permitted on each | S OR SECURITY THREAT  king arrangements for the eds of the patient are claim device shall be door and provisions shall |  | deficient practice will not recur, i.e; what quality assurance program will b into place.  2 audits per week X 1 mon be completed using the att. QAPI tool to ensure all kitc doors are able to open from egress side. This will be fol by 2 audits per month X 6 by the Maintenance Super designee, and quarterly the until the end of the year. The presented and reviewed Interdisciplinary Team at the meeting each month.  By what date the systemic changes for each deficient will be completed.  Systemic changes will be completed by 01/25/2023 | e put  th will ached hen n the llowed months visor or ereafter this will d by the he QAPI |
|                            | by: remote control  | apid removal of occupants<br>of locks; keying of all<br>ed by staff at all times; or                                   |  |   |   |

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Event ID:

1LSZ21

Facility ID: 000275

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) M                        | ULTIPLE CO | NSTRUCTION | (X3) DATE SURVEY  |       |            |
|--|--|-------------------------------|------------|------------|---|-------|------------|
| AND PLAN   | D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING |                               | UILDING    | <u>01</u>  | COMPL   |       |            |
|  |  | 155656                        | B. W       | ING        | _   | 01/10 | /2023      |
|  |  |                               | -          | STREET A   | ADDRESS, CITY, STATE, ZIP COD                                       |       |            |
| NAME OF I  | PROVIDER OR SUPPLIER                                   | ₹                             |            | 2827 NO    | ORTHGATE BLVD   |       |            |
| CANTER   | RBURY NURSING A  | AND REHABILITATION CENTER     |            | FORT V     | VAYNE, IN 46835   |       |            |
| (X4) ID  |  | STATEMENT OF DEFICIENCIE      |            | ID         | PROVIDER'S PLAN OF CORRECTION                                       |       | (X5)       |
| PREFIX   | `  | ICY MUST BE PRECEDED BY FULL  |            | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE    | COMPLETION |
| TAG  |  | R LSC IDENTIFYING INFORMATION |            | TAG        | DEFICIENCY)   |       | DATE       |
|  |  | e means available to the      |            |            |   |       |            |
|  | staff at all times.                                    | 226 1022251                   |            |            |   |       |            |
|  | 19.2.2.2.6   | .2.2.6, 19.2.2.2.5.1,         |            |            |   |       |            |
|  | SPECIAL NEEDS  | STOCKING                      |            |            |   |       |            |
|  | ARRANGEMENT  |                               |            |            |   |       |            |
|  |  | king arrangements for the     |            |            |   |       |            |
|  |  | ne patient are used, all of   |            |            |   |       |            |
|  |  | curity Locking requirements   |            |            |   |       |            |
|  |  | addition, the locks must be   |            |            |   |       |            |
|  | _  | at fail safely so as to       |            |            |   |       |            |
|  |  | of power to the device; the   |            |            |   |       |            |
|  |  | ed by a supervised            |            |            |   |       |            |
|  | • •  | er system and the locked      |            |            |   |       |            |
|  |  | d by a complete smoke         |            |            |   |       |            |
|  |  | (or is constantly monitored   |            |            |   |       |            |
|  |  | cation within the locked      |            |            |   |       |            |
|  |  | the sprinkler and detection   |            |            |   |       |            |
|  |  | nged to unlock the doors      |            |            |   |       |            |
|  | upon activation.                                       |                               |            |            |   |       |            |
|  | 18.2.2.2.5.2, 19.2                                     | .2.2.5.2, TIA 12-4            |            |            |   |       |            |
|  | DELAYED-EGRE   |                               |            |            |   |       |            |
|  | ARRANGEMENT  | S                             |            |            |   |       |            |
|  | Approved, listed of                                    | delayed-egress locking        |            |            |   |       |            |
|  | systems installed                                      | in accordance with            |            |            |   |       |            |
|  | 7.2.1.6.1 shall be                                     | permitted on door             |            |            |   |       |            |
|  | assemblies servin                                      | ng low and ordinary hazard    |            |            |   |       |            |
|  | contents in buildir                                    | ngs protected throughout by   |            |            |   |       |            |
|  | an approved, sup                                       | ervised automatic fire        |            |            |   |       |            |
|  |  | or an approved, supervised    |            |            |   |       |            |
|  | automatic sprinkle                                     | =                             |            |            |   |       |            |
|  | 18.2.2.2.4, 19.2.2                                     | .2.4                          |            |            |   |       |            |
|  |  | ROLLED EGRESS                 |            |            |   |       |            |
|  | LOCKING ARRAI  |                               |            |            |   |       |            |
|  |  | d Egress Door assemblies      |            |            |   |       |            |
|  |  | dance with 7.2.1.6.2 shall    |            |            |   |       |            |
|  | be permitted.  |                               |            |            |   |       |            |
|  | 18.2.2.2.4, 19.2.2                                     |                               |            |            |   |       |            |
|  |  | BY EXIT ACCESS                |            |            |   |       |            |
|  | LOCKING ARRAI  | NGEMENTS                      |            |            |   |       | l          |

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Event ID:

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Facility ID: 000275

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | î ´   |                              | (X3) DATE | X3) DATE SURVEY  |        |            |
|--|----------------------|---|------------------------------|-----------|--|--------|------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER                                       | A. BUILDING <u>01</u> COMPLI |           |  |        |            |
|  |                      | 155656  | B. WI                        | NG        |  | 01/10/ | 2023       |
| NAME OF D  | PROVIDER OR SUPPLIER | ·   |                              | STREET A  | ADDRESS, CITY, STATE, ZIP COD  |        |            |
|  |                      |   |                              |           | ORTHGATE BLVD  |        |            |
| CANTER   | BURY NURSING A       | ND REHABILITATION CENTER                                    |                              | FORT V    | VAYNE, IN 46835  |        |            |
| (X4) ID  |                      | STATEMENT OF DEFICIENCIE                                    |                              | ID        | PROVIDER'S PLAN OF CORRECTION  |        | (X5)       |
| PREFIX   |                      | ICY MUST BE PRECEDED BY FULL                                |                              | PREFIX    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE     | COMPLETION |
| TAG  |                      | R LSC IDENTIFYING INFORMATION                               |                              | TAG       | DEFICIENCE   |        | DATE       |
|  | 1                    | t access door locking in                                    |                              |           |  |        |            |
|  |                      | 7.2.1.6.3 shall be permitted                                |                              |           |  |        |            |
|  |                      | es in buildings protected<br>approved, supervised           |                              |           |  |        |            |
|  |                      | ection system and an  |                              |           |  |        |            |
|  |                      | ised automatic sprinkler                                    |                              |           |  |        |            |
|  | system.              | sod datomatio sprinkler                                     |                              |           |  |        |            |
|  | 18.2.2.2.4, 19.2.2   | 2.4   |                              |           |  |        |            |
|  |                      | on and interview, the facility                              | K 02                         | 222       | Based on observation and   |        | 01/25/2023 |
|  |                      | means of egress through 2 of                                | 11 02                        |           | interview, the staff members   |        | 01/25/2025 |
|  |                      | ts with special locking                                     |                              |           | working on 300 and 400 hall  |        |            |
|  | •                    | e clinical security needs of the                            |                              |           | did not know the code to ope   |        |            |
|  | _                    | ily accessible by remote                                    |                              |           | the exit door.   |        |            |
|  | control of locks; ke | ys carried by staff at all times;                           |                              |           | What corrective action will be   | е      |            |
|  | or other such reliab | le means available to the staff                             |                              |           | accomplished for those   |        |            |
|  |                      | eficient practice could affect 35                           |                              |           | residents found to have beer   | า      |            |
|  | residents on both M  | Iemory Care halls.  |                              |           | affected by the deficient  |        |            |
|  |                      |   |                              |           | practice   |        |            |
|  | Findings include:    |   |                              |           | The deficient practice was   |        |            |
|  |                      | id d Artis  |                              |           | immediately corrected by   |        |            |
|  |                      | on with the Maintenance                                     |                              |           | educating the staff members of   |        |            |
|  |                      | Iministrator on 01/10/23 at                                 |                              |           | codes to open the exit doors a   |        |            |
|  |                      | and 400 Memory Care Hall exit could be opened by entering a |                              |           | where to find them if they don'  | ι      |            |
|  |                      | I the hall had special locking                              |                              |           | remember the code.   | tho    |            |
|  | _                    | sidents with clinical security                              |                              |           | How other residents having t<br>potential to be affected by th                         |        |            |
|  | _                    | nembers working on the hall                                 |                              |           | same deficient practice will b   |        |            |
|  |                      | knew the code to open the exit                              |                              |           | identified and what correctiv  |        |            |
|  |                      | d no. Based on interview at                                 |                              |           | action(S) will be taken  | -      |            |
|  |                      | tion, the Maintenance Director                              |                              |           | All residents on the 300 and 4   | 00     |            |
|  |                      | the halls did not know the                                  |                              |           | Memory Care Halls have the   | -      |            |
|  | code to open the ex  |   |                              |           | potential to be affected by this   | i      |            |
|  |                      |   |                              |           | deficient practice. All staff wor  |        |            |
|  | This finding was re  | viewed with the Administrator                               |                              |           | on 300 and 400 halls on all sh   | -      |            |
|  | and Maintenance D    | irector during the exit                                     |                              |           | will be educated on the codes  | to     |            |
|  | conference.          |   |                              |           | open the exit doors and where  | e to   |            |
|  |                      |   |                              |           | find them if they don't rememb   | er     |            |
|  | 3.1-19(b).           |   |                              |           | the code.  |        |            |
|  |                      |   |                              |           | What measures will be put in   | 1      |            |
|  |                      |   |                              |           | place and what systemic  |        |            |

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Event ID:

1LSZ21

Facility ID: 000275

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2023 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155656                             | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction<br><u>01</u>   | (X3) DATE SURVEY COMPLETED 01/10/2023  |
|--------------------------|---------------------------------|---|--|--|--|
|                          | ROVIDER OR SUPPLIE              | R<br>AND REHABILITATION CENTER  | 2827 N                                     | ADDRESS, CITY, STATE, ZIP COD<br>IORTHGATE BLVD<br>WAYNE, IN 46835   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE                   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE   |
|                          |                                 |   |  | changes will be made to ensure that the deficient practice does not recur  1. All managers and all sta (existing and new) working or and 400 halls will be given an information card that has a lis the exit codes that can be wo with their ID badge  2. All managers will be educated regarding the codes the exit doors on the 300 and hallways and where they are located on the unit if they forg don't have the information car their ID badge.  3. All staff working on 300 400 halls will be educated regarding the codes to the exi doors on the 300 and 400 hallways and where they are located on the unit if they forg don't have the information car their ID badge.  How the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e; what quality assurance program will be p into place. 5 audits per week X 1 month be completed using the attact QAPI tool followed by 5 audits month X 6 months by the Maintenance Supervisor or designee, and quarterly thereafter. This will be presen and reviewed by the Interdisciplinary Team at the 6 | a 300  t of rn  s to 400  et or rd on  and  it  et or rd on  will  but  will  hed is per |

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| CENTERS FOI  | R MEDICARE & MEDIC  | AID SERVICES   |  |  | OM  | B NO. 0938-039             |
|--|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155656 |   |  | (X2) MULTIPLE C<br>A. BUILDING<br>B. WING                          | ONSTRUCTION  01  | (X3) DATE<br>COMPL<br>01/10/                      | ETED                       |
| NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER                               |   | 2827 N   | ADDRESS, CITY, STATE, ZIP COD<br>NORTHGATE BLVD<br>WAYNE, IN 46835 |  |   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)   | TE  | (X5)<br>COMPLETION<br>DATE |
| K 0226<br>SS=E<br>Bldg. 01   | with 7.2.4 and the through 18.2.2.5.7 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation failed to ensure 1 or sets were arranged latch. LSC section assemblies in horizon automatic-closin. Standard for Fire D Protectives, section doors shall swing exequipped with a clot to close and latch exideficient could affer compartments when Findings include:  Based on observation with the Maintenan 10:31 a.m., the 1 how was used as a horizon barrier. When tested to latch into the france in the section of | used, are in accordance provisions of 18.2.2.5.1 7, or 19.2.2.5.1 through  on and interview, the facility of 3 horizontal 1 hour fire door to automatically close and 7.2.4.3.10 requires all fire door to automatically close and 9.2.4.3.10 requires all fire door to an addition NFPA 80, the coors and Other Opening 6.1.4.2.1 states self-closing asily and freely and shall be sing device to cause the door ach time it is opened. This cut 40 residents in 2 smoke in occupied.  Ons during a tour of the facility one Director on 01/10/23 at our rated fire door by therapy ontal exit and as a smoke 1, one of the door leaves failed me due to a broken latch. at the time of observation, the | K 0226   | meeting each month.  By what date the systemic changes for each deficiency will be completed.  Systemic changes will be completed by 01/25/2023  Based on observation and interview, the facility failed to ensure 1 of 3 horizontal 1 hor fire door sets were arranged automatically close and latch. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The deficient practice could af 40 residents in 2 smoke compartments when occupied This deficient practice was immediately corrected by fixing the broken latch thus allowing fire door to automatically close and latch.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(S) will be taken | ur<br>to<br>1.<br>e<br>1<br>fect<br>g<br>the<br>e | 01/25/2023                 |

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Maintenance Director agreed one of the door

leaves did not latch and stated the door latch

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The deficient practice could affect

all occupied residents in the

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     |                                | (X2) M | ULTIPLE CO            | ONSTRUCTION   | (X3) DATE | SURVEY     |  |
|--|---------------------|--------------------------------|--------|-----------------------|---|-----------|------------|--|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER          | A. BU  | A. BUILDING <u>01</u> |   |           | COMPLETED  |  |
|  |                     | 155656                         | B. WI  | NG                    |   | 01/10/    | /2023      |  |
|  |                     |                                |        | _                     |   |           |            |  |
| NAME OF I  | PROVIDER OR SUPPLIE | R                              |        |                       | ADDRESS, CITY, STATE, ZIP COD   |           |            |  |
|  |                     |                                |        |                       | ORTHGATE BLVD   |           |            |  |
| CANTER   | RBURY NURSING       | AND REHABILITATION CENTER      |        | FORT                  | NAYNE, IN 46835   |           |            |  |
| (X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE       |        | ID                    | DROWINED'S DEAN OF CODDECTION   |           | (X5)       |  |
| PREFIX   | (EACH DEFICIE       | NCY MUST BE PRECEDED BY FULL   |        | PREFIX                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TC        | COMPLETION |  |
| TAG  | REGULATORY O        | R LSC IDENTIFYING INFORMATION  |        | TAG                   | DEFICIENCY)   | .16       | DATE       |  |
|  | needs to be readjus |                                |        |                       | facility. This deficient practice   | was       |            |  |
|  |                     |                                |        |                       | immediately addressed by  |           |            |  |
|  | This finding was re | eviewed with the Administrator |        |                       | auditing and ensuring all three   | <b>;</b>  |            |  |
|  | _                   | Director during the exit       |        |                       | horizontal 1 hour fire door sets  |           |            |  |
|  | conference.         |                                |        |                       | the facility automatically close  |           |            |  |
|  |                     |                                |        |                       | latch.  | unu       |            |  |
|  | 3.1-19(b).          |                                |        |                       | What measures will be put in  | ,         |            |  |
|  | 3.1 17(0).          |                                |        |                       | place and what systemic   |           |            |  |
|  |                     |                                |        |                       | changes will be made to   |           |            |  |
|  |                     |                                |        |                       | ensure that the deficient   |           |            |  |
|  |                     |                                |        |                       |   |           |            |  |
|  |                     |                                |        |                       | practice does not recur   | vicer     |            |  |
|  |                     |                                |        |                       | 1. The maintenance super  |           |            |  |
|  |                     |                                |        |                       | or designee will be educated t  |           |            |  |
|  |                     |                                |        |                       | ensure horizontal 1 hour fire d   |           |            |  |
|  |                     |                                |        |                       | sets are arranged to automation   | cally     |            |  |
|  |                     |                                |        |                       | close and latch.  |           |            |  |
|  |                     |                                |        |                       | 2. Audits will be put in place  |           |            |  |
|  |                     |                                |        |                       | to ensure all horizontal 1 hour   |           |            |  |
|  |                     |                                |        |                       | door sets automatically close   | and       |            |  |
|  |                     |                                |        |                       | latch per Life Safety Code  |           |            |  |
|  |                     |                                |        |                       | standards.  |           |            |  |
|  |                     |                                |        |                       | How the corrective action(s)  | will      |            |  |
|  |                     |                                |        |                       | be monitored to ensure the  |           |            |  |
|  |                     |                                |        |                       | deficient practice will not   |           |            |  |
|  |                     |                                |        |                       | recur, i.e; what quality  |           |            |  |
|  |                     |                                |        |                       | assurance program will be p   | ut        |            |  |
|  |                     |                                |        |                       | into place.   |           |            |  |
|  |                     |                                |        |                       | 2 audits per week X 1 month v   | vill      |            |  |
|  |                     |                                |        |                       | be completed using the attach   | ied       |            |  |
|  |                     |                                |        |                       | QAPI tool followed by 2 audits  | per       |            |  |
|  |                     |                                |        |                       | month X 6 months by the   |           |            |  |
|  |                     |                                |        |                       | Maintenance Supervisor or   |           |            |  |
|  |                     |                                |        |                       | designee, and quarterly therea  | after     |            |  |
|  |                     |                                |        |                       | until the end of the year. This   |           |            |  |
|  |                     |                                |        |                       | be presented and reviewed by  |           |            |  |
|  |                     |                                |        |                       | Interdisciplinary Team at the 0   |           |            |  |
|  |                     |                                |        |                       | meeting each month.   |           |            |  |
|  |                     |                                |        |                       | By what date the systemic   |           |            |  |
|  |                     |                                |        |                       | changes for each deficiency   |           |            |  |
|  |                     |                                |        |                       | will be completed.  |           |            |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155656 |   | X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 01/10/2023  |      |                     |   | ETED |                            |
|--|---|--|------|---------------------|---|------|----------------------------|
|  | ROVIDER OR SUPPLIER<br>BURY NURSING A   | ND REHABILITATION CENTER   |      | 2827 NO             | DDRESS, CITY, STATE, ZIP COD<br>DRTHGATE BLVD<br>VAYNE, IN 46835  |      |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | Ē    | (X5)<br>COMPLETION<br>DATE |
| K 0372<br>SS=E<br>Bldg. 01   | NFPA 101<br>Subdivision of Bui<br>Barrie  | lding Spaces - Smoke   |      |                     | Systemic changes will be completed by 01/25/2023  |      |                            |
|  | Subdivision of Bui<br>Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be patriers shall be patrium wall. Smoking duct penetration<br>systems where and is installed for smooth to the smoke barring 19.3.7.3, 8.6.7.1(1) Describe any medical system in REMAR   | pall be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.  ) hanical smoke control   | K 03 | 272                 | Based on observation and  |      | 01/25/2023                 |
|  | failed to ensure the passage of wire and smoke barrier walls smoke resistance of Section 19.3.7.5 requestion and shall have a min rating. LSC Section to be continuous froutside wall, from a smoke barrier to a scombination thereof for cables, cable travents, wires, and single electrical, mechanic communications systhoor, or floor/ceilin smoke barrier, or the | penetrations caused by the /or conduit through 2 of 10 were protected to maintain the each smoke barrier. LSC quires smoke barriers to be redance with LSC Section 8.5 mimum ½ hour fire resistive 8.5.2.1 requires smoke barriers on an outside wall to an a floor to a floor, or from a moke barrier, or by use of a f. 8.5.6.2 requires penetrations ys, conduits, pipes, tubes, milar items to accommodate | K 0. | 5/2                 | interview, the facility failed to ensure penetrations caused the passage of wire and/or conduit through 2 of 10 smoke barrier walls were protected to maintain the smoke resistant of each smoke barrier.  What corrective action will be accomplished for those residents found to have been affected by the deficient practice.  The deficient practice could affected the staff and at least 40 residents is smoke compartments when occupied. This deficient practice was immediately corrected by sealing the penetrations in the 200-hall and therapy smoke was | eect | 01/23/2023                 |

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/10/2023 155656 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2827 NORTHGATE BLVD CANTERBURY NURSING AND REHABILITATION CENTER FORT WAYNE. IN 46835 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE be protected by a system or material capable of How other residents having the restricting the movement of smoke. This deficient potential to be affected by the practice could affect staff and at least 40 residents same deficient practice will be in tthree smoke compartments. identified and what corrective action(S) will be taken Findings include: All the occupied residents of the facility could be potentially Based on observations during a tour of the facility affected. Therefore, this deficient with the Maintenance Director on 01/10/23 at practice was immediately 12:10 p.m., above the drop ceiling of the 200-hall addressed by ensuring that and therapy smoke walls there were two half inch penetrations were sealed gaps around wires. Based on interview at the time appropriately in all the hallways of observation, the Maintenance Director agreed and smoke walls. (100, 200, 300, there were unsealed penetrations in the 200-hall 400 and 500 hallways). and therapy smoke walls. What measures will be put in place and what systemic The finding was reviewed with the Administrator changes will be made to and the Maintenance Director during the exit ensure that the deficient conference. practice does not recur The maintenance supervisor or 3.1-19(b) designee will be educated to ensure that work completed by contractors in the future will be validated and verified so penetrations caused by the passage of wire and/or conduit through smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier. How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e; what quality assurance program will be put into place. 1 audit weekly X 1 month will be completed using the attached QAPI tool followed by 1 audit per month X 6 months by the

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Maintenance Supervisor or

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2023

FORM APPROVED

OMB NO. 0938-039

|  | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155656 | r ′ | JILDING   | onstruction (x) 01  | (3) DATE SURVEY COMPLETED 01/10/2023 |  |
|--|--|-----|---|---|--------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER |  |     | STREET ADDRESS, CITY, STATE, ZIP COD 2827 NORTHGATE BLVD FORT WAYNE, IN 46835 |   |                                      |  |
| (X4) ID  | SUMMARY STATEMENT OF DEFICIENCIE   |     | ID  | PROVIDER'S PLAN OF CORRECTION   | (X5)                                 |  |
| PREFIX   | (EACH DEFICIENCY MUST BE PRECEDED BY FU  | JLL | PREFIX  | CROSS-REFERENCED TO THE APPROPRIATE   | COMPLETION                           |  |
| TAG  | REGULATORY OR LSC IDENTIFYING INFORMAT   | ION | TAG   | DEFICIENCY)   | DATE                                 |  |
|  |  |     |   | designee, and one audit quarter thereafter until the end of the year. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month.  By what date the systemic changes for each deficiency will be completed.  Systemic changes will be completed by 01/25/2023 | d<br>/                               |  |

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