STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155656	A. BUILDING -- B. WING	01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN 46835

(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: 01/10/23 Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930 At this Emergency Preparedness survey, Canterbury Nursing and Rehabilitation Center 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 142 and had a census of 97 at the time of this survey. Quality Review completed on 01/11/23	E 0000	This facility is requesting paper compliance	
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: 01/10/23 Facility Number: 000275 Provider Number: 155656 AIM Number: 100290930 At this Life Safety Code survey, Canterbury Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation	K 0000	This facility is requesting paper compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meeta Anand	Executive Director	01/23/2023

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	in 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 with a partial second-story office occupancy was separated by a two hour floor assembly, 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 battery-operated smoke detectors in all resident rooms. The facility is fully protected by Type II 350 kW diesel powered generator. The facility has a capacity of 142 and had a census of 97 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had a detached garage containing lawn equipment, maintenance equipment, and supplies that was not sprinklered. Quality Review completed on 01/11/23			
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 ensure 1 of 3 exit doors in the kitchen were able to open from the egress side. LSC 19.2.2.1 states doors complying with 7.2.1 shall be	K 0211	**Based on observation and interview, the facility failed to ensure 1 of 3 exit doors in the kitchen were able to open from**	01/25/2023

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	permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could staff in the kitchen. Findings include: Based on observation with the Maintenance Director on 01/10/23 at 10:48 a.m., the kitchen exit door to the dining room did not open when tested due to a broken door handle. Based on interview at the time of observation, a kitchen worker stated the handle was not working properly and had to jiggle the door handle and pull up to open the door. The Maintenance Director agreed the door would not properly open and stated the handle needs to be replaced. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b).		**the egress side.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** No residents were found to have been affected by the deficient practice. The deficient practice affected the kitchen staff and was immediately addressed by replacing the broken door handle allowing the door to open easily. **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** All residents and kitchen staff have the potential to be affected by this deficient practice. This deficient practice was immediately addressed by ensuring all the three exits in the kitchen were able to open from the egress side. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** All kitchen staff and managers will be educated regarding the work order process when something is not working or out of service to ensure immediate resolution of the issue. **How the corrective action(s)will be monitored to ensure the**	

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			deficient practice will not recur, i.e; what quality assurance program will be put into place. 2 audits per week X 1 month will be completed using the attached QAPI tool to ensure all kitchen doors are able to open from the egress side. This will be followed by 2 audits per month X 6 months by the Maintenance Supervisor or designee, and quarterly 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	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or			

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	other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS			

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	Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 Memory Care exits with special locking arrangements for the clinical security needs of the residents were readily accessible by remote control of locks; keys carried by staff at all times; or other such reliable means available to the staff at all times. This deficient practice could affect 35 residents on both Memory Care halls. Findings include: Based on observation with the Maintenance Director and the Administrator on 01/10/23 at 11:30 p.m., the 300 and 400 Memory Care Hall exit doors were locked, could be opened by entering a four-digit code, and the hall had special locking arrangements for residents with clinical security needs. When staff members working on the hall were asked if they knew the code to open the exit doors, all staff stated no. Based on interview at the time of observation, the Maintenance Director agreed the staff on the halls did not know the code to open the exit door. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b).	K 0222	**Based on observation and interview, the staff members working on 300 and 400 hall did not know the code to open the exit door.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** The deficient practice was immediately corrected by educating the staff members of the codes to open the exit doors and where to find them if they don't remember the code. **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** All residents on the 300 and 400 Memory Care Halls have the potential to be affected by this deficient practice. All staff working on 300 and 400 halls on all shifts will be educated on the codes to open the exit doors and where to find them if they don't remember the code. **What measures will be put in place and what systemic**	01/25/2023

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			changes will be made to ensure that the deficient practice does not recur 1. All managers and all staff (existing and new) working on 300 and 400 halls will be given an information card that has a list of the exit codes that can be worn with their ID badge 2. All managers will be educated regarding the codes to the exit doors on the 300 and 400 hallways and where they are located on the unit if they forget or don't have the information card on their ID badge. 3. All staff working on 300 and 400 halls will be educated regarding the codes to the exit doors on the 300 and 400 hallways and where they are located on the unit if they forget or don't have the information card on their ID badge. **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.** 5 audits per week X 1 month will be completed using the attached QAPI tool followed by 5 audits per month X 6 months by the Maintenance Supervisor or designee, and quarterly thereafter. This will be presented and reviewed by the Interdisciplinary Team at the QAPI	

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			meeting each month. **By what date the systemic changes for each deficiency will be completed.** Systemic changes will be completed by 01/25/2023	
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 horizontal 1 hour fire door sets were arranged to automatically close and latch. LSC section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, the Standard for Fire Doors and Other Opening Protectives, section 6.1.4.2.1 states self-closing doors shall swing easily and freely and shall be equipped with a closing device to cause the door to close and latch each time it is opened. This deficient could affect 40 residents in 2 smoke compartments when occupied. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/10/23 at 10:31 a.m., the 1 hour rated fire door by therapy was used as a horizontal exit and as a smoke barrier. When tested, one of the door leaves failed to latch into the frame due to a broken latch. Based on interview at the time of observation, the Maintenance Director agreed one of the door leaves did not latch and stated the door latch	K 0226	**Based on observation and interview, the facility failed to ensure 1 of 3 horizontal 1 hour fire door sets were arranged to 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 affect 40 residents in 2 smoke compartments when occupied. This deficient practice was immediately corrected by fixing the broken latch thus allowing the 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** The deficient practice could affect all occupied residents in the	01/25/2023

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	needs to be readjusted. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b).		facility. This deficient practice was immediately addressed by auditing and ensuring all three horizontal 1 hour fire door sets in the facility automatically close and latch. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** 1. The maintenance supervisor or designee will be educated to ensure horizontal 1 hour fire door sets are arranged to automatically close and latch. 2. Audits will be put in place to ensure all horizontal 1 hour fire 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 put into place.** 2 audits per week X 1 month will be completed using the attached QAPI tool followed by 2 audits per month X 6 months by the Maintenance Supervisor or designee, and quarterly 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.**	

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			Systemic changes will be completed by 01/25/2023	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 10 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall	K 0372	**Based on observation and interview, the facility failed to ensure penetrations caused by the passage of wire and/or conduit through 2 of 10 smoke barrier walls were protected to maintain the smoke resistance 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 affect staff and at least 40 residents in 3 smoke compartments when occupied. This deficient practice was immediately corrected by sealing the penetrations in the 200-hall and therapy smoke walls.	01/25/2023

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	be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 40 residents in tthree smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/10/23 at 12:10 p.m., above the drop ceiling of the 200-hall and therapy smoke walls there were two half inch gaps around wires. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed penetrations in the 200-hall and therapy smoke walls. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**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** All the occupied residents of the facility could be potentially affected. Therefore, this deficient practice was immediately addressed by ensuring that penetrations were sealed appropriately in all the hallways and smoke walls. (100, 200, 300, 400 and 500 hallways). **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur** The maintenance supervisor or 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 Maintenance Supervisor or	

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			designee, and one audit quarterly 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	