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	09/30/2024

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: 09/30/24 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 115 at the time of this survey. Quality Review completed on 10/01/24	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: 09/30/24 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	10/14/2024

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 115 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 10/01/24			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 1 of 16 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or	K 0355	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 October 14, 2024.	10/07/2024

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	155756	A. BUILDING 01 B. WING	09/30/2024

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

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	replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice affects up to 12 residents, staff and visitors in the 100 Hall smoke compartment. Findings include: Based on observation with the Executive Director and Maintenance Director from 11:29 a.m. to 1:49 p.m. on 09/30/24, the fire extinguisher located in the 100 Hall dining room had an annual inspection date of April 2023. Based on interview at the time of observation, the Maintenance Director acknowledged the fire extinguisher annual inspection was past due and stated he was continuing with monthly inspections as evidenced with his initials and the date written on the expired annual inspection tag. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		It is the practice of this provider to ensure all portable fire extinguishers are selected, installed, inspected and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 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 fire extinguisher tag was replaced with the correct inspection date of June 2024. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction will be taken: Residents who reside on the 100 hall have the potential to be affected by the alleged deficient practice. After annual inspection of the fire extinguishers, the Maintenance Director will check to ensure that all extinguishers are inspected, and a new tag is provided on the device. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: After the annual inspection of the fire extinguishers, the Maintenance Director will check to ensure that all extinguishers are inspected, and a new tag is provided on the device. All fire	

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			extinguishers will be inspected monthly to ensure the pressure gage is reading, the locking pin in intact, the tamper seal is unbroken, the tank, hose, and nozzle are in good condition. After this has been completed, the inspection will be recorded on the provided tag. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: All fire extinguishers have been inspected and will be inspected monthly. The task is assigned to the Maintenance Director monthly in Direct Supply TELS. The task is checked off by the Maintenance Director/designee and validated by the Executive Director in QAPI. The task will be monitored monthly x 3 months and quarterly after to ensure 100% compliance. Fire extinguishers will be certified by a certified contractor annually. All tasks will be monitored and documented in TELs. 5. What date the systematic changes for each deficiency will be completed: The above deficiency was corrected 10/7/2024.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Based on record and interview, the facility failed to ensure 3 of 3 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA	K 0500	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth	10/11/2024

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	101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director, Director of Nursing, and Maintenance Director from 9:20 a.m. to 11:25 a.m. on 09/30/24, the following three water heaters had expired permits from Indiana Homeland Security: a. the water heater identified as state/permit # BP346968C had a permit with an expiration date of 11/13/2023. b. the water heater identified as state/permit # BP348033C had a permit with an expiration date of 03/05/2024. c. the water heater identified as state/permit # BP340793C had a permit with an expiration date of 04/10/2024. Based on interview, the Maintenance Director stated one of the water heaters was replaced and waiting for an inspection from the Insurance company inspector. He also stated that he needed to acquire new certificates from the online Indiana Portal for renewing the permits. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		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 October 14, 2024. 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. All three water heaters have been inspected to ensure they are in safe operating condition. Permits through the Department of Homeland Security have been requested. 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 residents have the potential to be affected by the alleged deficient practice. The water heaters have been inspected and all documentation has been updated to ensure they are in safe operating condition. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:	

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			The Maintenance Director will ensure that all water heaters are inspected at least annually. Documentation will be updated and available as necessary. The Maintenance Director will document the inspection in TELs. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The Maintenance Director will ensure all hot water heaters are inspected and are in safe operating condition on at least an annual basis. All documentation will be uploaded to TELs and the executive director/designee will validate completion. 5. What date the systematic changes for each deficiency will be completed: The above deficiency was corrected 10/11/2024.	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen storage room fire door assemblies was completed. LSC 19.3.2.4 states medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing. 8.7.1.1 states protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclosing the area with a fire barrier without	K 0761	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	10/07/2024

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	windows that has a 1-hour fire resistance rating in accordance with Section 8.3 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated		desk review in lieu of a post survey revisit on or before October 14, 2024. 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 oxygen storage room fire door inspection has been completed with no findings. 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 residents have the potential to be affected by the alleged deficient practice. The oxygen storage room door will be inspected at least annually by adding the inspection to the Annual Fire/Smoke Door Inspections. 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 obtained a certificate of completion for the Fire Door Inspection training course from Direct Supply TELS. The oxygen room fire door was added to the Annual smoke/fire door inspection checklist. This checklist will be utilized to ensure the doors are inspected at least annually. 4. How the corrective action will be monitored to ensure the deficient	

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	from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice affects up to 11 residents, staff and visitors in the 400 Hall smoke compartment. Findings include: Based on record review and interview with the Executive Director, Director of Nursing, and Maintenance Director from 9:20 a.m. to 11:25 a.m. on 09/30/24, no documentation of annual inspection of the oxygen storage room fire door assembly was available for review. Based on interview at the time of record review, the Maintenance Director stated an annual inspection was not conducted for the oxygen storage room fire door assembly in the last year. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		practice will not recur: The Quality Control Environmental Checklist will be utilized by the Maintenance Director/designee weekly x 4 weeks and monthly thereafter to ensure 100% compliance. The results of these audits will be reviewed by the QAPI committee which is overseen by the Executive Director. If the threshold is not achieved, and 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 10/7/2023.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 Housekeeping Manager's	K 0920	The creation and submission of this Plan of Correction does not	10/09/2024

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	office and of 1 Maintenance Director's office flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects up to 11 residents, staff and visitors in the 400 Hall smoke compartment. Findings include: Based on observation with the Executive Director and Maintenance Director from 11:29 a.m. to 1:49 p.m. on 09/30/24, the following was discovered: a) a surge protector in the Housekeeping Manager's office was powering two other surge protectors. One surge protector was powering a computer and peripherals, the other surge protector was not powering anything at the time of survey. b) a surge protector in the Maintenance Director's office was powering a computer and peripherals. Based on interview at the time of observation, the Maintenance Director acknowledged the power strips and unplugged them from each other at time of observation. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		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 October 14, 2024. 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. All surge protectors have been inspected to ensure that there are no surge protectors plugged into each other. 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 residents who reside on 400 Hall have the potential to be affected by the alleged deficient practice. All department leaders have been educated that surge protectors can not be plugged into each other. All offices have been inspected to ensure that surge protectors are being utilized properly. 3. What measures will be put into	

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			place or what systemic changes will be made to ensure that the deficient practice does not recur: All department heads have been educated to ensure understanding of the proper usage of surge protectors. The Maintenance Director/designee will audit the offices to ensure surge protectors are used correctly at least monthly using the audit tool attached. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The surge protector audit tool will be utilized by the Maintenance Director/designee monthly x 3 months and quarterly thereafter until 100% compliance is met. The results of these audits will be reviewed by the QAPI committee which is overseen by the Executive Director. If the threshold is not achieved, 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 10/7/2024.	