STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155654	A. BUILDING -- B. WING	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN 46809

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/24/22 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 At this Emergency Preparedness survey, Englewood Health & 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 67 certified beds. At the time of the survey, the census was 53. Quality Review completed on 10/24/22	E 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW FOR PAPER COMPLIANCE IN LIEU OF A POST SURVEY REVISIT on or after November 9, 2022.	
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: 10/24/22 Facility Number: 000498 Provider Number: 155654 AIM Number: 100266110 At this Life Safety Code survey, Englewood	K 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW FOR PAPER	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christian Livingston	Administrator	11/04/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Health & Rehabilitation Center was found not in compliance with Requirements for Participation 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 67 and had a census of 53 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached storage buildings. Quality Review completed on 10/24/22		COMPLIANCE IN LIEU OF A POST SURVEY REVISIT on or after November 9, 2022.	
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 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice	K 0211	**K211 Means of Egress - General** **Plan of Correction** **1. What corrective action(s) will be accomplished for those**	11/09/2022

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	could affect 15 residents in the Memory Care hall. Findings include: Based on an observation with the Maintenance Director on 10/24/22 at 11:30 a.m., by the Memory Care exit door there were over 20 boxes of supplies being stored in the corridor. Based on an interview at the time of observation, the Maintenance Director stated supplies were stored in the corridor due to lack of storage space in the building. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. 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 our Memory hall, 15 residents total, had the potential to be affected. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** The boxes were removed immediately and placed in appropriate storage locations. An additional storage bin has been purchased for inventory. Facility is currently waiting for storage bin to arrive to store excess inventory. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** The supplies will no longer be	

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			stored near the memory care exit door. We will immediately place all inventory in designated inventory closet locations.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff in the kitchen. Findings include: Based on observation with the Maintenance Director on 10/24/22 at 12:49 p.m., the portable K-class fire extinguisher located in the kitchen did not contain a conspicuously placed placard near	K 0355	**K355 Portable Fire Extinguishers** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. 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?** No residents had the potential to be affected regarding the deficient practice; however, all 5 staff members in the kitchen had the potential to be affected, but no employee was.	11/09/2022

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	the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Director agreed there was not a placard installed for the K-class fire extinguisher. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** A K-class fire extinguisher placard was ordered to be placed near the extinguisher. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** The placard will be placed next to the extinguisher and will not be moved. The placard has an expected delivery date of 11/7/2022.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not			

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	apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 35 resident room corridor doors resist the passage of smoke and capable of resisting fire for at least 20 minutes. This deficient practice could affect 2 residents in room 306. Findings include: Based on observation with the Maintenance Director on 10/24/22 between 12:00 p.m., the corridor door to room 306 had a quarter inch hole that went through the door. Based on interview at the time of observation, the Maintenance Director	K 0363	**K363 Corridor - Doors** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice.	11/09/2022

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	stated the hole was due the switching the door handle. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**2. 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?** Two residents had the potential to be affected by the deficient practice. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** The door handle was immediately replaced, and an expansion plate was installed to seal the holes. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** All door handles properly seal to resist the passage of smoke and are capable of resisting fire for at least 20 minutes. No door handles will be switched out without maintenance approval to ensure the deficient practice will not recur.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 receptacles within 6 feet from a sink were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff	K 0511	**K511 Utilities – Gas and Electric** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. 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?** No residents had the potential to be affected regarding the deficient practice; however, all staff in the facility had the potential to be affected, but no employee was. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** The receptacle was immediately replaced with a new GFCI outlet	11/09/2022

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	and visitors that would use the restroom by the dining room. Findings include: Based on observation the Maintenance Director on 10/24/22 at 12:45 p.m., there was an electric receptacle 24 inches from a sink in the restroom by the dining room. When tested with a GFCI tester, the receptacle did not disconnect from power. Based on interview at the time of observation, the Maintenance agreed the electric receptacle did not disconnect from power when tested. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		that is in proper working order. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** All receptacles within 24 inches from a sink are properly working GFCI receptacles. Only properly working GFCI receptacles will be installed within 24 inches from a sink.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are			

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	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect 15 residents in kitchen dining area and staff in the laundry. Findings include: Based on observation with the Maintenance Director on 10/24/22 at 12:40 p.m., the microwave in the kitchen and the air-conditioner in laundry were plugged into and supplied power by extension cords. Based on interview at the time of observation, the Maintenance Director acknowledged extension cords were in use and remove the extension cords. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0920	**K920 Electrical Equipment – Power Cords and Extension Cords** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. **2. 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 in the kitchen dining area, 15 residents total, had the potential to be affected. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** The extension cord for the	11/09/2022

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			microwave and the extension cord for the air conditioner were immediately removed. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** No extension cords will be used as a substitute for fixed wiring of a structure.	