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	07/23/2021

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: 07/23/21 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 56. Quality Review completed on 07/26/21	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 REVIEW on or after August 6, 2021.	
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: 07/23/21 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

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 56 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 07/26/21		COMPLIANCE IN LIEU OF A POST SURVEY REVIEW on or after August 6, 2021.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1			
	Based on observation and interview, the facility failed to maintain 1 of 5 exit discharges doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door	K 0211	Plan of Correction K 211 What corrective actions will be accomplished for those residents found to have been affected by the	08/06/2021

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	assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could 20 residents in the 100 hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/23/21 at 10:50 a.m., the 100-hall exit door was equipped with panic hardware, but the door would not open on the first try. It took three tries to open the door and took excessive force to open the door on the fourth try. Based on interview at the time of observation, the Maintenance Director stated the door sticks to the frame due to moisture and agreed it took excessive force to open the exit door. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		deficient practice? At the time the deficiency was identified, no residents were found to have been affected by the deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents on Old Mill Run and Sand Point halls, 30 resident total, had the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The magnet and strip on deficient door were immediately replaced. TLC contractors and electricians were contacted as well as LaForce the door manufacturer. Facility is currently waiting for door to arrive for replacement. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director or designee will audit all exit doors that are equipped with panic hardware weekly, Monday through Friday, to ensure that they are working properly and meet standards of operations and compliance. Any deficiencies will	

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			be brought to the administrator immediately. This practice will be part of scheduled preventive maintenance regimen. K211 Audit Tool - Means of Egress - General **MONTH** **WEEK 1** **WEEK 2** **WEEK 3** **WEEK 4** **WEEK 5** AUGUST SEPTEMBER OCTOBER NOVEMBER DECEMBER	

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			JANUARY FEBRUARY MARCH APRIL MAY JUNE JULY	

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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 2 horizontal exit 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 20 residents in 2 smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/23/21 at 10:30 a.m., the 1 ½ hour rated fire door set in a two-hour fire barrier between the lobby/admin area and the 200-hall was used as a horizontal exit. When tested the doors failed to latch into the frame due to the latch not catching. Based on interview at the time of observation, the Maintenance Director stated the fire door set was	K 0226	Plan of Correction K 226 What corrective actions 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. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents on Sand Point hall, 16 resident total, had the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	08/06/2021

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	not latching into the frame and would need repair. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		The deficient door was immediately repaired, strike plate was shimmed for proper fit so that door would latch into frame. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director or designee will audit all fire doors daily, 5 days a week to ensure that they are working properly and meet standards of operations and compliance. Any deficiencies will be brought to the administrator immediately. This practice will be part of scheduled preventive maintenance regimen. K226 Audit Tool - Horizontal Exits **MONTH** **DAY 1** **DAY 2** **DAY 3** **DAY 4** **DAY 5** **AUGUST** **SEPTEMBER**	

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			OCTOBER **NOVEMBER** **DECEMBER** **JANUARY** **FEBRUARY** **MARCH** **APRIL**	

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			MAY **JUNE** **JULY**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of			

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	hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 1 Maintenance and Paint Shops were protected as a hazardous area. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with Maintenance Director on 07/23/21 at 10:38 p.m., the maintenance room which contained paints and flammable storage was not protected as a hazardous area in that the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the corridor door to the maintenance room was not self-closing. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference.	K 0321	Plan of Correction K 321 What corrective actions 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. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents had the potential to be affected by the deficient practice. What measures will be put into place and what systemic changes	08/06/2021

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	3.1-19(b)		will be made to ensure that the deficient practice does not recur? An auto door closure was ordered to be installed on the deficient door. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance director and housekeeping supervisor share the office of deficient door; both personal have been instructed to ensure that door is completed closed and locked when entering or exiting office while awaiting part.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to			

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	NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression system was provided with an automatic fuel shut off. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition at 10.4.1 upon activation of any fire-extinguishing system for a cooking operation, all sources of fuel and electrical power that produce heat to all equipment requiring protection by that system shall automatically shut off. This deficient practice can affect 30 residents in the kitchen and dining room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/23/21 at 11:00 a.m., the kitchen was provided with a UL 300 hood suppression system. The automatic gas shutoff for the system could not be located. There was a power supply box behind the stove that was powered by UL 300 hood system, but the gas system was not hooked up to the box. Based on interview at the time of observation, the Maintenance Director agreed the automatic gas shutoff could not be located and stated the gas system was replaced about a year ago and it is possible the automatic gas shutoff was not reinstalled on the gas piping. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)	K 0324	Plan of Correction K 324 What corrective actions 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. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents had the potential to be affected by the deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All dietary staff were immediately in-serviced regarding where the gas valve was located and how to manually turn it off in the event of a fire. Safe care was contacted, and an automatic gas shut off will be installed. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what	08/06/2021

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			quality assurance program will be put into place? All dietary service staff will be educated as part of the on boarding orientation process if hired before installation occurs.	
K 0325 SS=E Bldg. 01	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
	Based on observation and interview, the facility failed to ensure 1 of over 20 alcohol-based hand sanitizer dispensers was not installed over an	K 0325	Plan of Correction K 325	08/06/2021

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	ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/23/21 at 11:30 a.m., an alcohol-based hand sanitizer dispenser was installed on the wall directly above a light switch in the break room. Based on interview at the time of observation, the Maintenance Director confirmed the alcohol-based hand sanitizer dispenser was installed on the wall directly above the light switch in the break room. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		What corrective actions 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. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions 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. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The alcohol-based hand sanitizer was immediately removed from above the light switch. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? No alcohol-based hand sanitizers will be placed above any light switches or other electrical current areas.	

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to maintain the ceiling construction in 1of 4 smoke compartments in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 10 residents in the main lobby Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/23/21 at 11:50 a.m., in the main lobby there were two	K 0351	Plan of Correction K 351 What corrective actions 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. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 01 B. WING	07/23/2021

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	sprinkler heads missing escutcheons. Based on interview at the time of observation, the Maintenance Director agreed there were two sprinklers in the lobby that did not have escutcheons. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		actions will be taken? All residents had the potential to be affected regarding the deficient practice. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? New Escutcheons have been ordered to install in the deficient fire sprinklers. The facility will also have a supply on hand if needed. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director or designee will audit and observe fire sprinklers weekly for any defective or missing escutcheons and replace immediately if needed. K351 Audit Tool - Sprinkler System Installation **MONTH** **WEEK 1** **WEEK 2** **WEEK 3** **WEEK 4** **WEEK 5** AUGUST	

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			SEPTEMBER OCTOBER NOVEMBER DECEMBER JANUARY FEBRUARY MARCH	

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			APRIL MAY JUNE JULY	