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	01/11/2024

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: 01/11/24 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 88 at the time of this survey. Quality Review completed on 01/16/24	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: 01/11/24 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
Jamie Solomon	AIT	01/26/2024

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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	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 88 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 01/16/24			
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 8 corridor exits were provided with an unobstructed level walking surface in accordance with LSC Chapter 7. Section 7.1.6.3	K 0211	This facility is requesting paper compliance. · what corrective action(s) will be accomplished for those residents	02/09/2024

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	states walking surfaces shall comply with all of the following: (1) Walking surfaces shall be nominally level. (2) The slope of a walking surface in the direction of travel shall not exceed 1 in 20, unless the ramp requirements of 7.2.5 are met. (3) The slope perpendicular to the direction of travel shall not exceed 1 in 48. This deficient practice can affect 25 residents in the 200-hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 01/11/24 at 11:20 a.m., by the smoke doors to the 200 hall the floor was wavey and had round indents in the floor. The area measured about 8 x 3 feet. The condition becomes a tripping hazard for residents. Based on interview at the time of observation, the Maintenance Director, agreed there was an 8 x 3 feet section of the floor was uneven and not level. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		found to have been affected by the deficient practice; The corrective action will be corrected by JT Construction (contract company) by ensuring that walking surface and the round indents near the smoke doors on 200 hall was leveled. Please see attached letter of intent by JT Construction. · 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; To ensure that other residents in the building are not affected by this deficient practice, all the hallways in the facility were inspected By JT Construction to ensure that corridor exits are provided with an unobstructed walking surface to prevent trip hazards for all residents in the building. Please see attached letter from JT · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director, Maintenance Assistant and Interdisciplinary Team will be educated on the LSC Chapter 7. Section 7.1.6.3 by the Director of Property Management · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place; and QAPI Audit Tool "K 211 Floor care Audit Tool" will be completed weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months by the Maintenance Director or designee. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. If 100% is not achieved an action plan will be developed. · by what date the systemic changes for each deficiency will be completed. The systemic changes will be completed by February 9 2024	
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 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			

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	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 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			

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	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 1 of 2 exits on the 400-hall 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 20 residents on the 400-memory care hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 01/11/24 at 11:20 a.m., the 400-hall exit door by room 417 was locked, had an Access-Controlled key pad, and the hall had special locking arrangements for residents with clinical security needs; but when staff entered the code to open the door the door did not release and open. When the fire alarm was activated using a pull station the door did release and open. This condition would delay evacuation of the building during other non-fire emergencies. Based on interview at the time of observation, the Maintenance Director, stated the code being used did not open the door, but the code was found about an hour later and did release the door when tested. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0222	This facility is requesting paper compliance. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The deficient practice was immediately corrected by ensuring the current exit door codes are accurate, updated and communicated with staff members to ensure they know how 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 current codes to open the exit doors and where to find them if they don't remember the code. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · Maintenance Director and designee (Maintenance Assistant) will be educated by the Director of	02/09/2024

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			Property Management to ensure that the current exit door codes are accurate, updated and communicated with staff members to ensure they know how to open the exit doors and where to find them if they don't remember the code. · Interdisciplinary team and all staff (existing and new) working on 300 and 400 halls will be given an information card that has a current list of the exit codes that can be worn with their ID badge. · Interdisciplinary team and all staff working on 300 and 400 hall will be educated by Maintenance Director or designee regarding the current 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; and QAPI Audit Tool- "K 222- 300 Hall Exit door codes" and "K 222- 400 Hall Exit Door Codes" will be completed weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months by the Maintenance Director or designee. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. If 100% is not achieved an action plan will be	

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			developed. By what date the systemic changes for each deficiency will be completed. The systemic changes will be completed by February 9, 2024	
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 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 observation and interview, the facility failed to ensure 1 of 3 cook tops were disconnected from power whenever the kitchen (Bistro) is not under staff supervision. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking	K 0324	This facility is requesting paper compliance. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The deficient practice was immediately corrected by the	02/09/2024

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	facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect 10 residents using the Bistro. Findings include: Based on observation with the Maintenance Director on 01/11/24 at 11:00 a.m., there was a cooktop in the Bistro that was separated from the corridor, but the unattended cooktop was connected to power. Based on interview at the time of observation, the Maintenance Director stated staff forgot to disconnect the cooktop from power, and the Maintenance Director did disconnect the cooktop from power and locked the switch. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance Director by disconnecting the power from the cooktop and locked the switch. · 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 500 Hall using the Bistro have the potential to be affected by the deficient practice. The deficient practice was immediately corrected by the Maintenance Director by disconnecting the power from the cooktop and locked the switch. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Interdisciplinary team and all staff will be educated that cook tops need to be disconnected from power and to lock the switch whenever the kitchen (Bistro) is not under staff supervision. · 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; QAPI Audit Tool- K 324 - Cooking Equipment" will be completed weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months by the Maintenance Director or designee. This will be presented and reviewed by the Interdisciplinary Team at the QAPI	

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			meeting each month. If 100% is not achieved an action plan will be developed. · By what date the systemic changes for each deficiency will be completed. The systemic changes will be completed by February 9, 2024	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric 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 8 electrical outlets in the Bistro, 1 of 3 electrical outlets in the 500-hall nurses' station, and 1of 6 electrical outlets in the breakroom contained a cover plate and did not have exposed electrical terminals. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 40 residents in room in three smoke compartments. Findings include: Based on observation with the Maintenance Director on 01/11/24 between 10:00 a.m. and 12:00 p.m., in the Bistro and the 500-hall nurses' station	K 0511	This facility is requesting paper compliance. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The deficient practice was immediately corrected by ensuring the electrical outlets in the Bistro, 500 hall nurses station and in the breakroom were replaced with receptacle faceplates and ensured there were no exposed terminals. · 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 facility can be affected by the deficient practice. The deficient practice will be	02/09/2024

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	there were electrical outlets with missing cover plates. Also in the breakroom, part of an outlet was damage exposing metal terminals. Based on interview at the time of observation, the Maintenance Director agreed outlets were missing a cover plates, were physically damaged, and there were electrical contacts visible. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		corrected to ensure all electrical outlets in the facility are compliant with NFPA 70, 2011 Edition. Article 406.6 (F) and if not compliant, they will be replaced with receptacle faceplates and ensured there are no exposed terminals. All other outlets were checked to ensure they are in good repair by the maintenance director. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · Maintenance Director and designee (Maintenance Assistant) will be educated by the Director of Property Management on NFPA 70, 2011 Edition. Article 406.6 (F) which states that Exposed Terminals and Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. · Interdisciplinary team and all staff will be educated by the Maintenance Director that all electrical outlets need to have cover plates and outlets should not be damaged with exposing metal terminals. If damaged outlet is identified, a work order needs to be generated so maintenance department can address it immediately. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place QAPI Audit Tool- “K 511-Electrical Outlets” will be completed weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months by the Maintenance Director or designee. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. If 100% is not achieved an action plan will be developed. · By what date the systemic changes for each deficiency will be completed. The systemic changes will be completed by February 9, 2024	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent.			

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	18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 8 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect staff and up to 25 residents in the 200-hall. Findings include: Based on observations with the Maintenance Director on 01/11/24 at 9:30 a.m., 11:30 a.m., and again at 12:31 p.m., there were two 33-gallon soiled linen/trash barrels on the 200-hall. Based on interview at the time of observation, the Maintenance Director stated there were two 33-gallon barrels of soiled linen/trash totaling 66 gallons in a 64 square foot area on the 200-hall. The findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0754	This facility is requesting paper compliance. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action was immediately corrected by the Maintenance Director by ensuring the existing 33 gallons trash receptacles were relocated in a room protected as a hazardous area when not attended in accordance with FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 · 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 facility can be affected by the deficient practice. Therefore, all existing 33 gallons trash receptacles will either be replaced with 32 gallons capacity or will be located in a room protected as a hazardous area when not attended in accordance with FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; · The Housekeeping supervisor or designee will be educated by Director of Housekeeping on the FM Approval Standard 6921 or	02/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING 01 B. WING	01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			equivalent. 18.7.5.7, 19.7.5.7 which states that Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. · Interdisciplinary Team and all staff will be educated that when not attended, the trash receptacles will be located in a room protected as a hazardous area. · 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 QAPI Audit Tool- “K 754- Linen and Trash Receptacles” will be completed weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months by the Maintenance Director or designee. This will be presented and reviewed by the Interdisciplinary Team at the QAPI meeting each month. If 100% is not achieved an action plan will be developed. · By what date the systemic	

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			changes for each deficiency will be completed. The systemic changes will be completed by February 9, 2024	