STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155656		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  01/11/2024	
	PROVIDER OR SUPPLIER	L ND REHABILITATION CENTER	2827 N	ADDRESS, CITY, STATE, ZIP COD IORTHGATE BLVD WAYNE, IN 46835	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	(X5) COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFERENCE	DATE
Bldg			E 0000	This facility is requesting pape compliance.	:r
	Facility Number: 00 Provider Number: 1 AIM Number: 1002	00275 55656			
	Canterbury Nursing found in compliance Preparedness Requi Medicaid Participat CFR 483.73. The fa had a census of 88 a	Preparedness survey, g and Rehabilitation Center was e with Emergency rements for Medicare and ing Providers and Suppliers, 42 ucility has a capacity of 142 and at the time of this survey.			
K 0000					
Bldg. 01	Licensure Survey w		K 0000	This facility is requesting pape compliance.	iT
	Provider Number: 1 AIM Number: 1002 At this Life Safety ( Nursing and Rehabi	55656			
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE
Jamie Solo	omon		AIT		01/26/2024

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155656		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/11/2024	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		2827 N	ADDRESS, CITY, STATE, ZIP COD ORTHGATE BLVD VAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	in Medicare/Medica Life Safety from Fir National Fire Protec Life Safety Code (I Health Care Occupa This one-story facil office occupancy w floor assembly, was (111) construction, facility has a fire ala detection in the corr corridors and batter all resident rooms. by Type II 350 kW facility has a capaci 88 at the time of thi All areas where resi were sprinklered. T garage containing la equipment, and sup	aid, 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, .SC), Chapter 19, Existing ancies and 410 IAC 16.2.  ity with a partial second-story as separated by a two hour a determined to be of Type V and was fully sprinklered. The arm system with smoke ctidors, areas open to the y-operated smoke detectors in The facility is fully protected diesel powered generator. The ty of 142 and had a census of					
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of with an unobstructed.	General ays, corridors, exit cations, and accesses are chapter 7, and the means accesses are full use in case of s modified by 18/19.2.2 1.	K 02	211	This facility is requesting pape compliance.  · what corrective action(s) will accomplished for those reside	be	02/09/2024

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155656	B. W	ING		01/11/	/2024
		1		CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			ORTHGATE BLVD		
CANTED	DLIDV NI IDSING /	AND REHABILITATION CENTER					
CANTER	BURT NURSING F	AND REHABILITATION CENTER		FORT	WAYNE, IN 46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	aces shall comply with all of			found to have been affected b	y the	
	the following:				deficient practice;		
		es shall be nominally level.			The corrective action will be		
		walking surface in the direction			corrected by JT Construction		
		exceed 1 in 20, unless the ramp			(contract company) by ensurir	-	
	requirements of 7.2				that walking surface and the r		
		endicular to the direction of			indents near the smoke doors		
	travel shall not exc				200 hall was leveled. Please s	see	
	-	tice can affect 25 residents in			attached letter of intent by JT		
	the 200-hall.				Construction.		
					· how other residents having t		
	Findings include:				potential to be affected by the		
					same deficient practice will be	;	
		vation during a tour of the			identified and what corrective		
		aintenance Director on 01/11/24			action(s) will be taken;		
		e smoke doors to the 200 hall			To ensure that other residents		
		y and had round indents in the			the building are not affected b	У	
		asured about 8 x 3 feet. The			this deficient practice, all the		
		a tripping hazard for residents.			hallways in the facility were		
		at the time of observation, the			inspected By JT Construction	to	
		tor, agreed there was an 8 x 3			ensure that corridor exits are		
	feet section of the f	floor was uneven and not level.			provided with an unobstructed		
					walking surface to prevent trip		
	-	reviewed with the Maintenance			hazards for all residents in the		
	Director during the	exit conference.			building. Please see attached		
	2.1.10(1.)				letter from JT		
	3.1-19(b)				· what measures will be put in		
					place and what systemic char	-	
					will be made to ensure that the		
					deficient practice does not rec	:ur;	
					The Maintenance Director,		
					Maintenance Assistant and		
					Interdisciplinary Team will be	. 7	
					educated on the LSC Chapter		
					Section 7.1.6.3 by the Directo	1 01	
					Property Management		
					· how the corrective action(s)	WIII	
					be monitored to ensure the	_	
					deficient practice will not recu	Γ,	
			1		i.e., what quality assurance	Į.	I

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STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>				COMPLETED	
		155656	B. WI	NG		01/11/2024		
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		2827 NO	DDRESS, CITY, STATE, ZIP COD ORTHGATE BLVD VAYNE, IN 46835			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDED'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·= 	DATE	
K 0222 SS=E Bldg. 01	be equipped with a requires the use of egress side unless special locking arrocking arrocking. Where special lockinical security neused, only one lock permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times.	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements:  OR SECURITY THREAT king arrangements for the reds of the patient are king device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or a means available to the 2.2.6, 19.2.2.2.5.1,			program will be put into place; QAPI Audit Tool "K 211 Floor Audit Tool" will be completed weekly times 4 weeks then eve 2 weeks times 4 weeks then monthly for at least 6 months it the Maintenance Director or designee. This will be presente and reviewed by the Interdisciplinary Team at the Comeeting each month. If 100% not achieved an action plan wideveloped.  by what date the systemic changes for each deficiency wide completed. The systemic changes will be completed by February 9 2024	care ery  py ed  QAPI is ill be		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155656	B. W	ING		01/11/	/2024
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C		2827 NO	ORTHGATE BLVD		
CANTER	BURY NURSING A	ND REHABILITATION CENTER	_	FORT V	VAYNE, IN 46835		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DESCRIPTION OF		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	SPECIAL NEEDS						
	ARRANGEMENT						
	•	king arrangements for the					
		e patient are used, all of					
		curity Locking requirements					
	-	addition, the locks must be					
		at fail safely so as to					
	•	of power to the device; the ed by a supervised					
		er system and the locked					
	·	by a complete smoke					
	•	(or is constantly monitored					
	-	ation within the locked					
		the sprinkler and detection					
		iged to unlock the doors					
	upon activation.	igoa to amoon the abore					
	18.2.2.2.5.2, 19.2	.2.2.5.2. TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT						
		lelayed-egress locking					
		in accordance with					
		permitted on door					
		g low and ordinary hazard					
		igs protected throughout by					
	an approved, sup	ervised automatic fire					
	detection system	or an approved, supervised					
	automatic sprinkle	er system.					
	18.2.2.2.4, 19.2.2	.2.4					
	ACCESS-CONTR	OLLED EGRESS					
	LOCKING ARRAI	NGEMENTS					
	Access-Controlled	d Egress Door assemblies					
	installed in accord	lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					
		BY EXIT ACCESS					
	LOCKING ARRAI	NGEMENTS					
	-	t access door locking in					
		7.2.1.6.3 shall be permitted					
	on door assemblie	es in buildings protected					
	throughout by an	approved, supervised					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155656	B. W	NG		01/11/2024	
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD  ORTHGATE BLVD		
CANTER	DELIDY NI IDSING A	AND REHABILITATION CENTER		l	WAYNE, IN 46835		
CANTER	ADURT NURSING F	AND REHABILITATION CENTER		FORT	WATNE, IN 40833		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	REFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	automatic fire det	ection system and an					
	approved, superv	ised automatic sprinkler					
	system.						
	18.2.2.2.4, 19.2.2						
		on and interview, the facility	K 0	222	This facility is requesting pape	r	02/09/2024
		means of egress through 1 of			compliance.		
		nall with special locking			· what corrective action(s) will		
	_	e clinical security needs of the			accomplished for those reside		
		ily accessible by remote			found to have been affected b	y the	
		ys carried by staff at all times;			deficient practice;		
		le means available to the staff			The deficient practice was		
		eficient practice could 20			immediately corrected by ensu	ıring	
	residents on the 400	0-memory care hall.			the current exit door codes are	)	
					accurate, updated and		
	Findings include:				communicated with staff mem		
					to ensure they know how to or	en	
		ration during a tour of the			the exit doors and where to fin		
		aintenance Director on 01/11/24			them if they don't remember the	ne	
		00-hall exit door by room 417			code.		
		Access-Controlled key pad,			· how other residents having the	ne	
	_	ecial locking arrangements for			potential to be affected by the		
		cal security needs; but when			same deficient practice will be		
		de to open the door the door			identified and what corrective		
		open. When the fire alarm was			action(s) will be taken;		
		all station the door did release			All residents on the 300 and 4	00	
		dition would delay evacuation			Memory Care Halls have the		
		ng other non-fire emergencies.			potential to be affected by this		
		at the time of observation, the			deficient practice. All staff wor	-	
		tor, stated the code being used			on 300 and 400 halls on all sh		
	•	or, but the code was found			will be educated on the curren		
		and did release the door when			codes to open the exit doors a		
	tested.				where to find them if they don'	t	
	T1 C 1	the first of the section			remember the code.		
	_	reviewed with the Maintenance			· what measures will be put in		
	Director during the	exit conference.			place and what systemic chan	•	
	2.1.10(1)				will be made to ensure that the	_	
	3.1-19(b)				deficient practice does not rec	ur;	
					Maintenance Director and	4\	
					designee (Maintenance Assist		
			1		will be educated by the Director	or of	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155656		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/11/2024		
	PROVIDER OR SUPPLIED	ND REHABILITATION CENTER		2827 N	ADDRESS, CITY, STATE, ZIP COD ORTHGATE BLVD WAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					Property Management to ensuthat the current exit door code are accurate, updated and communicated with staff mem to ensure they know how to op the exit doors and where to fin them if they don't remember the code.  Interdisciplinary team and all staff (existing and new) working 300 and 400 halls will be given information card that has a cullist of the exit codes that can be worn with their ID badge.  Interdisciplinary team and all staff working on 300 and 400 will be educated by Maintenar Director or designee regarding current codes to the exit doors the 300 and 400 hallways and where they are located on the if they forget or don't have the information card on their ID backnown they are located on the deficient practice will not recur i.e., what quality assurance program will be put into place; QAPI Audit Tool- "K 222- 300 Exit door codes" and "K 222- 4 Hall Exit Door Codes" will be completed weekly times 4 week then every 2 weeks times 4 we then monthly for at least 6 mo by the Maintenance Director of designee. This will be present and reviewed by the Interdisciplinary Team at the Competing each month. If 100% not achieved an action plan we are the plan we are they are the plan with the control of the present and reviewed an action plan we are they are	bers bers ben id ne ng on n an rrent be hall nce g the s on unit adge. will f, and Hall 400 eks eeks nths or ed QAPI is	

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER 155656  NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER  IN (A) ID PREETX TAG  SUMMARY STATIANISM OF DESICIENCE: (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  K (324 NFPA 101  Cooking Facilities Cooking apulpment (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 in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, 2.5 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  Regulation of the provided 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  Regulation of the provided 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 through 18.3.2.5.5 through 18.3.2.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER  (CAN) DESUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO)  (FORT WAYNE, IN 46835  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CAS)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (CACH DEFICIENCY MUST BE INFORMATION)  (CACH DEFICIENCY MUST BE INFORMATION OR LINE INFORMATION OR				A. BUILDING <u>01</u> COMPLETED					
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER  (X4) ID  PREFIX TAG  SIMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  K 0324  NFPA 101  SS=E Cooking Facilities Cooking Facilities Cooking acquipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking in accordance with 18.3.2.5.2, 19.3.2.5.2  **residential cooking operations, unless:** **residential cooking acquipment (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 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  **STRECT ADDRESS, CITY, STATE, ZIP COD 2827 NORTHGATE BLVD FORT WAYNE, IN 48835  CDD.  **PREFIX**  TAG  **CORTING REPRECISOTOR THE MAYNE, IN 46835  **COOKING REPRECISOTOR THE MAYNE				ı					
AMME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER  (X4) ID PREFIX TAG  SIMMARY STATIMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR I.S.C IDENTIFYING INFORMATION  K 0324 SS=E Bidg. 01  Cooking Facilities Cooking Facilities Cooking Facilities Cooking Facilities Cooking Operations, unless: *residential cooking operations, unless: *residential cooking operations, unless: *residential cooking operations, unless: *cooking in accordance with 18.3.2.5.4, 19.3.2.5.2, 19.3.2.5.2  *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.4, 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 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				<u> </u>	OTD PPT	ADDRESS CITY STATE ZIP COP			
CANTERBURY NURSING AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCE (ACCH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (ACCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION  (X5) COMPLETION  (ACCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION  (X5) COMPLETION  (ACCH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION  (X6) developed.  By what date the systemic changes will be completed. The systemic changes for each deficiency will be completed by February 9, 2024  (X6) ACC Socking Facilities  Cooking Facilities  Cooking Facilities  Cooking quipment is protected in accordance with INFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking quipment (i.e., small appliances such as microwaves, not 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 conditions under 18.3.2.5.4, 19.3.2.5.4, 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 92.3 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  This facility is requesting paper compliance.  *what corrective action(s) will be accomplished for those residents	NAME OF P	ROVIDER OR SUPPLIEF	₹						
IXA) ID   SUMMARY STATEMENT OF DEFICIENCE   (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   Geveloped.	CANTED	BLIDA VILIDGIVIC V	AND DEHABILITATION CENTED						
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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  K 0324  This facility is requesting paper compliance. · what corrective action(s) will be accomplished for those residents		•							
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    NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be enclosed as hazardous areas, but shall not be enclosed as hazardous areas, but shall not be open to the corridor.    K 0324   This facility is requesting paper compliance.   · what corrective action(s) will be accomplished for those residents									
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  K 0324  This facility is requesting paper compliance.  • what corrective action(s) will be accomplished for those residents		•							
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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  K 0324 This facility is requesting paper compliance. • what corrective action(s) will be accomplished for those residents		•							
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  K 0324  This facility is requesting paper compliance.  • what corrective action(s) will be accomplished for those residents		_							
failed to ensure 1 of 3 cook tops were disconnected from power whenever the kitchen (Bistro) is not under staff supervision. LSC  compliance.  • what corrective action(s) will be accomplished for those residents		•		K O	324	This facility is requesting page	er	02/09/2024	
disconnected from power whenever the kitchen (Bistro) is not under staff supervision. LSC  • what corrective action(s) will be accomplished for those residents				10.	1 40	1		02/07/2027	
(Bistro) is not under staff supervision. LSC accomplished for those residents			-			•	be		
			-						
		, ,	-						
residential or commercial cooking equipment that deficient practice;			•				,		
is used to prepare meals for 30 or fewer persons  The deficient practice was						•			
shall be permitted, provided that the cooking immediately corrected by the			-						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155656	B. WI	NG		01/11/	2024
		<u> </u>	<del>'                                    </del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			ORTHGATE BLVD		
CANTER	BURY NURSING A	ND REHABILITATION CENTER			VAYNE, IN 46835		
	Г				,	1	are:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	conditions:	ith all of the following			Maintenance Director by	41	
		ining the cooking equipment			disconnecting the power from		
	is not a sleeping roo				cooktop and locked the switch		
		ining the cooking equipment			<ul> <li>how other residents having the potential to be affected by the</li> </ul>		
		rom the corridor by partitions			·		
	_	3.6.2 through 19.3.6.5.			same deficient practice will be identified and what corrective		
		ts of 19.3.2.5.3(1) through (10)			action(s) will be taken;		
	and (13) are met.	65 17.5.2.5.5(1) unougn (10)			All residents on 500 Hall using	ı the	
		A switch meeting all of the			Bistro have the potential to be		
	following is provide	_			affected by the deficient practi		
		, or a switch located in a			The deficient practice was	ce.	
		is provided within the cooking			immediately corrected by the		
		ates the cooktop or range.			Maintenance Director by		
	1	ed to deactivate the cooktop			disconnecting the power from	the	
	1 ' '	the kitchen is not under staff			cooktop and locked the switch		
	supervision.	are kiterion is not under starr			· what measures will be put in		
		ice could affect 10 residents			place and what systemic chan		
	using the Bistro.	10 10 010 0110 010 10 100100110			will be made to ensure that the	-	
					deficient practice does not rec		
	Findings include:				Interdisciplinary team and all s		
	8				will be educated that cook top		
	Based on observation	on with the Maintenance			need to be disconnected from		
		4 at 11:00 a.m., there was a			power and to lock the switch		
		o that was separated from the			whenever the kitchen (Bistro)	is	
		attended cooktop was			not under staff supervision.		
		. Based on interview at the			· how the corrective action(s)	will	
	_	, the Maintenance Director			be monitored to ensure the		
	stated staff forgot to	disconnect the cooktop from			deficient practice will not recu	-,	
	power, and the Mai	ntenance Director did			i.e., what quality assurance		
	disconnect the cook	top from power and locked			program will be put into place;		
	the switch.				QAPI Audit Tool- K 324 - Cool		
					Equipment" will be completed		
	The findings were r	reviewed with the Maintenance			weekly times 4 weeks then ev	ery	
	Director during the	exit conference.			2 weeks times 4 weeks then		
					monthly for at least 6 months	by	
	3.1-19(b)				the Maintenance Director or		
					designee. This will be present	ed	
					and reviewed by the		
			1		Interdisciplinary Team at the C	DAPI	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155656		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 01/11/2024			
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2827 NORTHGATE BLVD FORT WAYNE, IN 46835				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0544	NEDA 404			meeting each month. If 100% not achieved an action plan w developed.  By what date the systemic changes for each deficiency w be completed.  The systemic changes will be completed by February 9, 202	ill be		
K 0511 SS=E Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observation failed to ensure 1 of Bistro, 1 of 3 electronurses' station, and breakroom contained have exposed electrical Edition. Article 406 (Cover Plates), require installed so as to and seat against the 2011 Edition. Article Receptacles shall be terminals are not existed the exposed electrical receptacies. The exposed in three smoke complete installed so as to and seat against the 2011 Edition. Article Receptacles shall be terminals are not existed existed the exposed electrical representation. The exposed electrical representation of the exposed electrical representation of the exposed electrical representation.	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in no hazard to life. 9.1.1, 9.1.2 on and interview, the facility F8 electrical outlets in the fical outlets in the 500-hall 10f 6 electrical outlets in the did a cover plate and did not ical terminals. NFPA 70, 2011 66, Receptacle Faceplates hires receptacle faceplates shall completely cover the opening mounting surface. NFPA 70, the 406.5 (F) Exposed Terminals, the enclosed so that live wiring posed to contact. This build affect 40 residents in room partments.	K 0511	This facility is requesting paper compliance.  · what corrective action(s) will accomplished for those reside found to have been affected by deficient practice;  The deficient practice was immediately corrected by ensurement the electrical outlets in the Bis 500 hall nurses station and in breakroom were replaced with receptacle faceplates and ensurement there were no exposed terming 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 ints y the  uring tro, the iured als. he		
	Director on 01/11/2	4 between 10:00 a.m. and 12:00 nd the 500-hall nurses' station		affected by the deficient practi The deficient practice will be			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155656	B. W	ING		01/11/	2024
				_			
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					ORTHGATE BLVD		
CANTER	BURY NURSING A	AND REHABILITATION CENTER		FORT	VAYNE, IN 46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	there were electrica	l outlets with missing cover			corrected to ensure all electric	al	
	plates. Also in the b	preakroom, part of an outlet			outlets in the facility are comp	liant	
	was damage exposi	ng metal terminals. Based on			with NFPA 70, 2011 Edition.		
	interview at the tim	e of observation, the			Article 406.6 (F) and if not		
	Maintenance Direct	tor agreed outlets were missing			compliant, they will be replace	d	
	a cover plates, were	e physically damaged, and			with receptacle faceplates and		
	there were electrica	l contacts visible.			ensured there are no exposed		
					terminals. All other outlets wer		
	The findings were r	reviewed with the Maintenance			checked to ensure they are in		
	Director during the	exit conference.			good repair by the maintenand	ce	
					director.		
	3.1-19(b)				· what measures will be put in	to	
					place and what systemic chan	ges	
					will be made to ensure that the		
					deficient practice does not rec	ur;	
					· Maintenance Director and		
					designee (Maintenance Assist	ant)	
					will be educated by the Directo	or of	
					Property Management on NFF		
					70, 2011 Edition. Article 406.6	(F)	
					which states that Exposed		
					Terminals and Receptacles sh		
					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 shoul		
					not be damaged with exposing	-	
					metal terminals. If damaged o		
					is identified, a work order need		
					be generated so maintenance		
					department can address it		
					immediately.	. 20	
					· how the corrective action(s)	WIII	
					be monitored to ensure the	_	
					deficient practice will not recui	,	
l l	Ī		1		i.e., what quality assurance		

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	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155656		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/11/2024	
	ROVIDER OR SUPPLIER BURY NURSING A	ND REHABILITATION CENTER	2827	r address, city, state, zip cod NORTHGATE BLVD WAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0754 SS=E Bldg. 01	shall not exceed 3 average density of room or space shat gallons/square feet capacity of 32 gall within any 64 squal linen or trash collectorated in a room area when not atted. Containers used spermitted to be extracted in a round are understood in a room area when not atted. Containers used spermitted to be extracted in a round are understood in a round area when are used spermitted to be extracted in a round area when and containers for average and containers for round area when and containers for round area when are used in the same area when area when are used in the same area when are used in the same area when area when are used in the same area when	Frash Containers sh collection receptacles 2 gallons in capacity. The f container capacity in a all not exceed 0.5 st. A total container cons shall not be exceeded are feet area. Mobile soiled are feet area. Mobile soiled are feet area and ball be protected as a hazardous ended. olely for recycling are cluded from the above are each container is less 5 gallons unless attended, combustibles are labeled are females.		program will be put into place QAPI Audit Tool- "K 511- Electrical Outlets" will be completed weekly times 4 we then every 2 weeks times 4 w then monthly for at least 6 mc by the Maintenance Director of designee. This will be present and reviewed by the Interdisciplinary Team at the off meeting each month. If 100% not achieved an action plan with developed.  By what date the systemic changes for each deficiency with be completed. The systemic changes will be completed by February 9, 202	eks reeks onths or ted  QAPI is vill be	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
	155656		B. WING		01/11/2024		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			ORTHGATE BLVD		
CANTERBURY NURSING AND REHABILITATION CENTER					WAYNE, IN 46835		
_					,		W.5
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR TAG:			(X5)	
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		Dia relation		DATE
	18.7.5.7, 19.7.5.7	on and interview, the facility	K 0754		This facility is requesting paper		02/00/2024
		_					02/09/2024
	failed to ensure trash receptacles in 1 of 8 corridors were maintained in accordance with				compliance.  · what corrective action(s) will be		
		ient practice could affect staff					
	and up to 25 resider	-	accomplished for those r		T		
	and up to 23 resider	its in the 200-han.		found to have been affect		y trie	
	Findings include:				deficient practice; The corrective action was		
	i manigs include:				immediately corrected by the		
	Rased on observativ	ons with the Maintenance			Maintenance Director by ensu	rina	
		4 at 9:30 a.m., 11:30 a.m., and			the existing 33 gallons trash	ilig	
		, there were two 33-gallon soiled			receptacles were relocated in	2	
		on the 200-hall. Based on			room protected as a hazardou		
		e of observation, the			area when not attended in	3	
					accordance with FM Approval		
	Maintenance Director stated there were two 33-gallon barrels of soiled linen/trash totaling 66				Standard 6921 or equivalent.		
	gallons in a 64 square foot area on the 200-hall.				18.7.5.7, 19.7.5.7		
	ganons in a 04 square root area on the 200-han.				· how other residents having the	he	
	The findings were reviewed with the Maintenance				potential to be affected by the		
	Director during the exit conference.		same deficient practice will be				
	8				identified and what corrective		
	3.1-19(b)				action(s) will be taken;		
	,				All residents in the facility can	be	
					affected by the deficient practi		
					Therefore, all existing 33 gallo		
					trash receptacles will either be		
					replaced with 32 gallons capa		
					or will be located in a room	-	
					protected as a hazardous area	a	
					when not attended in accorda	nce	
					with FM Approval Standard 69	921	
					or equivalent. 18.7.5.7, 19.7.5	.7	
					· what measures will be put in	to	
					place and what systemic chan	ges	
					will be made to ensure that the		
					deficient practice does not rec		
					· The Housekeeping superviso	or or	
					designee will be educated by		
					Director of Housekeeping on t		
					FM Approval Standard 6921 o	r	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155656		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  01/11/2024	
	ROVIDER OR SUPPLIE	R AND REHABILITATION CENTER	2827 N	ADDRESS, CITY, STATE, ZIP C IORTHGATE BLVD WAYNE, IN 46835	OD	
(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
				equivalent. 18.7.5.7, 19 which states that Soiled trash collection recepta not exceed 32 gallons The average density of capacity in a room or s not exceed 0.5 gallons feet. A total container of 32 gallons shall not be within any 64 square fe Mobile soiled linen or to collection receptacles of capacities greater than shall be located in a ro protected as a hazardo when not attended.  Interdisciplinary Team staff will be educated th not attended, the trash receptacles will be located room protected as a hasarea.  how the corrective act be monitored to ensure deficient practice will no i.e., what quality assura program will be put into QAPI Audit Tool- "K 75 and Trash Receptacles completed weekly time then every 2 weeks time then monthly for at leas by the Maintenance Di designee. This will be p and reviewed by the Interdisciplinary Team meeting each month. If not achieved an action developed.  By what date the systems	d linen or acles shall in capacity. If container pace shall /square capacity of exceeded eet area. rash with 32 gallons om ous area and all hat when ated in a azardous tion(s) will ee the ot recur, ance of place 64- Linen 67 will be es 4 weeks es 6 months rector or o	

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AND THE PROPERTY AND A PROPERTY AND								
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDEA		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED		
		155656						
		155656	B. WING			01/11/2024		
	PROVIDER OR SUPPLIER BURY NURSING A	ND REHABILITATION CENTER		2827 N	ADDRESS, CITY, STATE, ZIP COD NORTHGATE BLVD WAYNE, IN 46835			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE	
					changes for each deficiency w be completed. The systemic changes will be completed by February 9, 202			

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