STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. BUILDING -- B. WING	09/25/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/25/23 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 At this Emergency Preparedness survey, Coventry Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 150 and had a census of 122 at the time of this survey. Quality Review completed on 09/26/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/25/23 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 At this Life Safety Code survey, Coventry Meadows was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Hardy	Executive Director	10/09/2023

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

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 150 and had a census of 122 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/26/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 1 smoke barrier doors in the 300-hall. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 20 staff and residents.	K 0100	K100 The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be	10/09/2023

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	Findings include: Based on observation with the Maintenance Assistant and the Maintenance Director of a sister facility on 09/25/23 between 11:30 a.m. and 1:16 p.m., the set of smoke barrier doors to the 300-hall next to room 301 was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the Maintenance Assistant agreed the smoke doors were equipped with latching devices, but the doors did not properly latching when tested due to the latch being installed incorrectly. The finding was reviewed with the Maintenance Assistant and Maintenance Director during the exit conference. 3.1-19(b)		considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident, this facility respectfully requests a desk review in lieu of a post survey revisit on or before October 9, 2023. 1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents were found to be affected from the alleged deficient practice. All latching smoke barrier doors have been inspected and are functioning properly. The 300-hall has been repaired and is functioning properly. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction will be taken: The Maintenance Director/designee has inspected all smoke barrier doors to ensure all are latching and functioning properly. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director and assistant have been educated to ensure all smoke barrier doors are functioning properly. The Maintenance Director/designee will monitor the functionality of the latching smoke barrier doors	

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			utilizing the Quality Control Environmental Checklist. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The Quality Control Environmental Checklist will be utilized by the Maintenance Director/designee weekly x 4 weeks and monthly thereafter to ensure 100% compliance. The results of these adutis will be reviewed by the QAPI committee which is overseen by the Executive Director. If the threshold is not achieved, and action plan will be developed to ensure compliance. 5. What date the systematic changes for each deficiency will be completed: The above deficiency was corrected 10/9/2023.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			

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	Based on observation and interview, the facility failed to ensure penetrations through 1 of 5 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 20 residents in one smoke compartments. Findings include: Based on observations with the Maintenance Assistant and a Maintenance Director from a sister facility on 09/25/23 between 11:30 a.m. and 1:16 p.m., above the drop ceiling of the smoke wall next to room 207, there was an approximate 2 inch circular shaped hole. Based on interview at the time of observation, the Maintenance Assistant agreed there was an unsealed penetration in the smoke barrier and stated that previous work was being conducted above the ceiling which could have caused the issue and acknowledged that it was not sealed properly. The finding was reviewed with the Maintenance	K 0372	K372 The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident, this facility respectfully requests a desk review in lieu of a post survey revisit on or before October 9, 2023. 1. What corrective action(s) will be accomplished for those residents found to be affected by the deficient practice: No residents were found to be affected from the alleged deficient practice. The smoke barrier next to room 207 has been repaired. All other smoke barriers have been inspected and meet the parameters of LSC Section 8.5. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction will be taken: The Maintenance Director/designee has inspected all smoke barrier walls and ensured they meet LSC 8.5. 3. What measures will be put into place or what systemic changes will be made to ensure that the	10/09/2023

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	Assistant and a Maintenance Director during the exit conference. 3.1-19(b)		deficient practice does not recur: The Maintenance Director and assistant have been educated to ensure all 3rd party vendor work is inspected and no holes are present in smoke barrier walls when work is completed. The Maintenance Director/designee will inspect the smoke barrier walls monthly to ensure they all meet LSC 8.5. The Maintenance Director/designee will also inspect work completed by any 3 party vendors to ensure it meets the regulation. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The Quality Control Environmental Checklist will be utilized by the Maintenance Director/designee weekly x 4 weeks and monthly thereafter to ensure 100% compliance. The results of these audits will be reviewed by the QAPI committee which is overseen by the Executive Director. If the threshold is not achieved, an action plan will be developed to ensure compliance. 5. What date the systematic changes for each deficiency will be completed: The above deficiency was corrected 10/9/2023.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and	K 0761	K761.	10/09/2023

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	interview, the facility failed to ensure annual inspection and testing of 1 of 8 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.		The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident, this facility respectfully requests a desk review in lieu of a post survey revisit on or before October 9, 2023. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents have been affected by the alleged deficient practice. The oxygen storage/transfilling room door has been inspected and is functioning properly. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The Maintenance Director has inspected all fire doors and all are functioning properly (see audit tool). 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director and Assistant have been in serviced on	

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	(7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on record review with the Maintenance Assistant and a Maintenance Director from a sister facility on 09/25/23 between 09:40 a.m. and 11:27 a.m., documentation of fire door inspections were provided. However, no documentation could be located to determine if the oxygen storage/transfilling room door had been inspected within the last 12 months. Based on observation during a tour of the facility between 11:30 a.m. and 1:16 p.m., the fire rating tag on the oxygen storage/transfilling room was listed at 1-1/2 hours. Based on interview at the time of record review and observation, the Maintenance Assistant acknowledged the aforementioned issue and stated that the door was not listed on the most recent fire door inspections and would have to have one conducted. Findings were discussed with the Maintenance Assistant and Maintenance Director at exit conference. 3.1-19(b)		the frequency in which the fire door must be inspected. The oxygen storage/transfilling room door has been added to the annual inspection list. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The Quality Control Environmental Checklist will be utilized by the Executive Director/Designee or Maintenance Director/Designee weekly x 4 weeks then monthly to ensure 100% compliance is achieved. The results of these audits will be reviewed by the QAPI Committee overseen by the Executive Director. If the threshold is not achieved, an action plan will be developed to ensure compliance. 5. What date the systemic changed for each deficiency will be completed: October 9, 2023.	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could	K 0920	K920. The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based upon past survey history and no harm	10/09/2023

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	affect approximately 3 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Assistant and a Maintenance Director from a sister facility on 09/25/23 between 11:30 a.m. and 1:16 p.m., in the Medical Records office a power strip used to power equipment, was not secured, and was dangling from the outlet in the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Assistant agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Assistant and a Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Assistant and a Maintenance Director from a sister facility on 09/25/23 between 11:30 a.m. and 1:16 p.m., a		identified to any resident, this facility respectfully requests a desk review in lieu of a post survey revisit on or before October 9, 2023. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents have been affected by the alleged deficient practice. All flexible cords utilized in the facility have been installed properly and used in a safe manner. All high power draw equipment has been inspected and plugged directly into a wall outlet. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The Maintenance Director has inspected all areas of the building utilizing power strips and ensured they are secured and not dangling from the outlet and ensured all high power draw equipment is plugged directly into the wall (see audit tool). 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All staff will be serviced on the proper usage of a surge protector to ensure they are secured and not dangling from walls. The in service will also include education	

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	refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Physical Therapy gym. Furthermore, a water sanitizer which contained a heating element (high draw power) was plugged into and supplied power by a power strip in the Therapy Office in the Therapy Gym. Based on interview at the time of record review, the Maintenance Assistant agreed the two appliances were plugged into and were supplied power by power strips. Both power strips were removed upon observation. Findings were discussed with the Maintenance Assistant and a Maintenance Director at exit conference. 3.1-19(b)		that major appliances (high power draw equipment must be plugged directly into a wall outlet). Customer care representatives will ensure compliance during daily room rounds. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: The Quality Control Environmental Checklist will be utilized by the Executive Director/Designee or Maintenance Director/Designee weekly x 4 weeks then monthly to ensure 100% compliance is achieved. The results of these audits will be reviewed by the QAPI Committee overseen by the Executive Director. If the threshold is not achieved, an action plan will be developed to ensure compliance. 5. What date the systemic changed for each deficiency will be completed: October 9, 2023.	