

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2012
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NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280
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K0000	<p>An Initial Life Safety Code Certification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 07/12/12</p> <p>Facility Number: 012836 Provider Number: 012836 AIM Number: NA</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor, Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Warner Transitional Services, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was constructed in two sections that is separated by a 2 hour fire wall. The one story main building built in 1991 was determined to be of Type V</p>	K0000	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed with this Response and Plan of Correction.</p> <p>In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filled solely because of the requirements under State and federal law that mandate submission of a Plan of Correction within specified days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>(111) construction and was fully sprinklered except for the eaves outside the exits of the main building. The main building has a fire alarm system with smoke detection in the corridors, areas open to the corridor and hard-wired smoke detectors in 56 of 62 resident rooms. The two story day program area building built in 2004 was determined to be of Type III (211) construction and was fully sprinklered. The day program building has a fire alarm system with no smoke detection in the corridor or spaces open to the corridors. The facility construction type was determined to be V (111). The facility has a capacity of 96 and had a census of 0 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage or smoke detector coverage.</p> <p>All areas where clients have customary access were sprinklered.</p> <p>A detached two story maintenance building of Type II (000) construction with a separate fire alarm system where clients do not have customary access was not sprinklered and a detached mini barn constructed of wood with a wood floor used for storage of shovels, rakes and other similar equipment was not</p>						

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	<p>sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/19/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0017	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 open use areas were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K0017	<p>Building #2: Smoke detectors installed in 2nd floor of day program fish bowl and HR conference room by Simplex Grinnell on 7/24/12. The Facilities Coordinator (Maintenance Supervisor) will assure testing of all smoke detectors per Fire Safety regulations, including 2 year sensitivity testing of all smoke detectors. Any smoke detector that is broken or not functioning properly will be immediately replaced. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/18/2012

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	<p>detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any client as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the lounge identified as S-158 in the main building lacked separation from the corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open areas were not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 07/12/12 during the time of observation, with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the above areas were open to the corridor without supervision from the nurses' station and was not protected by automatic smoke detection.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/22/2012
FORM APPROVED
OMB NO. 0938-0391

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	3.1-19(b)				07/24/2012

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K0018	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure doors protecting corridor openings did not have an impediment to the closing of the doors to protect 96 of 96 clients. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the following was noted:</p> <p>a. All client sleeping room doors were provided with a kick down door stop. b. Numerous other corridor doors were either provided with a kick down door</p>	K0018	<p>1 a. All kick down door stops have been removed in resident sleeping rooms by WTS Maintenance on 7/16/12. b. The two corridor doors in Rm. C-160 and the set of dining room doors (room C-184) have positive latching hardware installed by Door Service Supply on 7/20/12. The Facilities Coordinator will assure in weekly rounds that there are no kick down door stops or wedges/related instruments of any kind present to hold doors open. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/20/2012			

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	<p>stop or were wedged open.</p> <p>Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged all client sleeping room doors as well as other corridor doors were propped open.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 4 of at least 300 corridor doors were provided with positive latching hardware. This deficient practice could affect any client, staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the following was noted:</p> <p>a. The two corridor doors in the recreation room (C-160) and the set of dining room doors (C-184) lacked positive latching hardware.</p> <p>Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire</p>						

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	<p>Protection Engineer, it was acknowledged the recreation and dining room doors were not provided with positive latching hardware.</p> <p>3.1-19(b)</p>			

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K0021	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 doors to hazardous areas such as a kitchen or a laundry were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the kitchen and laundry room doors were equipped with kick down door stops which, when engaged, prevented the doors from closing. Based on interview on 07/12/12</p>	K0021	<p>Kick down door stops have been removed from the kitchen and laundry room doors by WTS Maintenance on 7/16/12. The Facilities Coordinator will assure in weekly rounds that there are no kick down door stops or wedges/other instruments of any kind present that could hold these doors open. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/16/2012			

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	<p>during the time of observation, with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the doors would not automatically close when the fire alarm was activated.</p> <p>3.1-19</p>			

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K0025	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 10 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect approximately all clients, staff and/or visitors using the corridors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during</p>	K0025	<p>The 2 inches in diameter penetrations in the attic smoke barrier wall outside Rm. C-166 are repaired. Additionally, WTS Maintenance has inspected all smoke barrier attic walls throughout the facility for penetrations and fire stopped where any penetrations were found. Repairs and full inspection completed 7/24/12. The Facilities Coordinator will assure attic smoke barrier walls are not penetrated by minimum of monthly checks and a full annual inspection of attic smoke barrier walls. Any penetration of attic smoke barrier walls will be immediately repaired by facility maintenance. Special attention will be given to assuring that any penetration from maintenance work is immediately addressed. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed</p>	07/24/2012			

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	a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, there were two penetrations two inches in diameter through the attic smoke barrier outside room C-166 that were not fire stopped. Based on interview during the tour from 12:15 p.m. to 3:45 p.m., the Maintenance Supervisor indicated the facility was in the process of running cable through the attic smoke barriers. 3.1-19(b)		monthly.				

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K0027	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 2 doors within 10 smoke barriers were equipped with the appropriate hardware to ensure the doors are self-closing. This deficient practice could affect clients as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the following was noted:</p> <p>a. The closet door in the recreation/activity supply (C-165) identified as part of a smoke barrier wall on the Fire Safety Features Record Drawings dated 07/10/12 lacked a door closer.</p> <p>b. The west door door in the conference</p>	K0027	<p>a. A door closer was installed on the closet door in Rm. C-165 by WTS Maintenance on 7/20/12.</p> <p>b. A door closer was installed on the west conference room door in Rm. C-183 by WTS Maintenance on 7/23/12. The Facilities Coordinator will in weekly rounds immediately replace / repair any door closures found to not be operating properly. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/23/2012			

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	<p>room (C-183) identified as part of a smoke barrier wall on the "Fire Safety Features Record Drawings" dated 07/10/12 lacked a door closer.</p> <p>Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the smoke barrier doors lacked door closers.</p> <p>3.1-19(b)</p>			

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K0046	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on interview and observation, the facility failed to provide exterior emergency lighting for 12 of 12 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect all occupants in the facility including staff, visitors and clients if the facility were required to evacuate in an emergency and the generator was providing electricity at the time.</p> <p>Findings include:</p> <p>Based on interview on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was unknown if the exterior lights for the exit discharge for all of the facility exits were connected to the generator. Observation of the electrical circuit breaker box tied into the generator did not indicate if any of the exterior lights were connected to the generator.</p> <p>3.1-19(b)</p>	K0046	<p>The exterior exit lights to the residential center are connected to the generator and are designated on the generator circuit breaker box. Electrical system check and panel labeling was completed 7/20/12 by Deem Electric. Emergency exit lighting for the day program building is on battery backup and batteries are replaced annually. The Facilities Coordinator will continue to assure the generator and emergency exit lighting remain in proper working order per semi-annual and as required generator maintenance. The Facilities Coordinator will in weekly preventative maintenance rounds address any damaged / broken lighting to be replaced immediately. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/20/2012			

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K0051	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control panels, located in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice could affect all clients, staff and visitors in the</p>	K0051	<p>A smoke detector was installed above the fire alarm control panel in Rm. C-172 by Superior Systems on 7/18/12. The Facilities Coordinator will assure all required testing, including two year sensitivity testing of all smoke detectors in completed in a timely manner. At any time any smoke detector that is broken or found not to be functioning properly will be immediately replaced. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/18/2012			

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	<p>facility.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the fire alarm control panel located in the folding room (C-172) was not provided with automatic smoke protection. Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the folding room lacked automatic smoke detection.</p> <p>3.1-19(b)</p>						

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K0054	<p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure 100 % of smoke detectors had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity</p>	K0054	<p>All ducts detectors were tested for sensitivity by Superior Systems on 7/20/12 and all were working properly. Documentation is on file in the Facility Coordinator's office. The Facilities Coordinator will assure duct sensitivity testing is conducted at minimum within each 2 year requirement and as needed. Additionally, Facilities Coordinator will assure that a full Fire Protection Systems inspection is performed according to annual regulations. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/20/2012			

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	<p>test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of "Smoke Detector Sensitivity Test" dated 06/01/2012 on 07/12/12 during record review from 9:45 a.m. to 11:00 a.m. with the Maintenance Supervisor, the test report did not include results for ten duct detectors identified on the "Periodic Fire Alarm Inspection & Test Report" dated 06/01/2012. Based on interview during the review, the Maintenance Supervisor acknowledged the duct detectors were not included in the</p>						

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	documentation. 3.1-19(b)			

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K0056	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 8 of 8 combustible exterior canopies which were wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect all clients as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, all exterior eaves above the main building exits measured five feet and five inches in width and were not sprinklered. Based on interview</p>	K0056	<p>All exterior eaves above facility exits exceeding 4 feet in width are spinklered. Work performed by Superior Systems and was completed on 7/24/12. The Facilities Coordinator will assure that Fire Protection Systems inspections are performed on all sprinklers annually and necessary repairs/maintenance will be preformed immediately and as needed. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/24/2012

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	<p>on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the exterior eaves above the main building exits exceeded four feet in width and were not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K0144	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure electrical outlets supplied from the emergency electrical system in 2 of 6 corridors had a distinct marking so as to be readily identifiable. NFPA 99, 1999 Edition, Standard for Health Care Facilities, 3-4.2.2.4 (b)(2) requires cover plates for the electrical receptacles or the electrical receptacles themselves supplied from the emergency system shall have a distinctive color or marking so as to be readily identifiable. This deficient practice could affect all clients, staff and visitors in the day program building.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, emergency electrical outlets located on the first and second floor of the day program building lacked distinctive color or markings. Based on interview on 07/12/12 during the time of observation with the Maintenance Supervisor, it was acknowledged some</p>	K0144	<p>Electrical outlets in the day program building that are on the generator are in red and are labeled on the day program building generator panel in the electrical room. This was completed on 7/20/12 by Deem ElectricThe Facilities Coordinator will continue to assure the generator remains in proper working order per semi-annual and as required generator maintenance and minimum of weekly preventative maintenance rounds that electrical outlets are in proper working order. Any damaged / broken electrical outlets will be replaced immediately. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/20/2012			

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	<p>electrical outlets in the day program building were on the generator but it was not known which ones were.</p> <p>3.1-19(b)</p>			

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K0211	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of 1 alcohol based hand rub dispensers within the laundry was not installed over an ignition source. This deficient practice could affect any staff using the laundry.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, an alcohol based hand rub dispenser was mounted on the wall directly above an electric outlet. Based on interview on 07/12/12 during the time of observation with the</p>	K0211	<p>The alcohol based hand rub dispenser directly above an electrical outlet was removed from the wall in the laundry on 7/16/12 by WTS Maintenance. The Facilities Coordinator in weekly rounds will assure that no dispensers are installed over or adjacent to an ignition source. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/16/2012			

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	<p>Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the dispenser was mounted directly above an electric outlet.</p> <p>3.1-19(b)</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to install smoke detectors in each client's room before July 1, 2012. This deficient practice could affect at least 6 clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during</p>	K9999	Client rooms (N-150; N-149; N-114; N-113; S-155 & S-156) were equipped with smoke detectors by Superior Systems on 7/16/12. The Facilities Coordinator will assure 2 year sensitivity testing of all smoke detectors. At any time any smoke detector is broken or found to be not functioning properly it will be immediately replaced. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.	07/16/2012			

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	<p>a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the following client rooms were not provided with smoke detectors: N-150, N-149, N-114, N-113, S-155 and S-156. Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged not all the client rooms were provided with smoke detectors.</p> <p>3.1-19(ff)</p>			

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K0000	<p>An Initial Life Safety Code Certification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 07/12/12</p> <p>Facility Number: 012836 Provider Number: 012836 AIM Number: NA</p> <p>Surveyors: Dennis Austill, Life Safety Code Supervisor, Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Warner Transitional Services, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was constructed in two sections that is separated by a 2 hour fire wall. The one story main building built in 1991 was determined to be of Type V</p>	K0000	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed with this Response and Plan of Correction.</p> <p>In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and federal law that mandate submission of a Plan of Correction within specified days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p>				

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	<p>(111) construction and was fully sprinklered except for the eaves outside the exits of the main building. The main building has a fire alarm system with smoke detection in the corridors, areas open to the corridor and hard-wired smoke detectors in 56 of 62 resident rooms. The two story day program area building built in 2004 was determined to be of Type III (211) construction and was fully sprinklered. The day program building has a fire alarm system with no smoke detection in the corridor or spaces open to the corridors. The facility construction type was determined to be V (111). The facility has a capacity of 96 and had a census of 0 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage or smoke detector coverage.</p> <p>All areas where clients have customary access were sprinklered.</p> <p>A detached two story maintenance building of Type II (000) construction with a separate fire alarm system where clients do not have customary access was not sprinklered and a detached mini barn constructed of wood with a wood floor used for storage of shovels, rakes and other similar equipment was not</p>						

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	<p>sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/19/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0017	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 open use areas were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any client as well as visitors and staff.</p>	K0017	<p>Building #2: Smoke detectors installed in 2nd floor of day program fish bowl and HR conference room by Simplex Grinnell on 7/24/12. The Facilities Coordinator (Maintenance Supervisor) will assure testing of all smoke detectors per Fire Safety regulations, including 2 year sensitivity testing of all smoke detectors. Any smoke detector that is broken or not functioning properly will be immediately replaced. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/18/2012			

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	<p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the second floor day program work room/conference room lacked separation from the corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 18.3.6.1 was not met as follows: the open areas were not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 07/12/12 during the time of observation, with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the above areas were open to the corridor without supervision from the nurses' station and was not protected by automatic smoke detection.</p> <p>3.1-19(b)</p>			07/24/2012
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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 open use areas were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any client as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire</p>	K0017	<p>Building #2: Smoke detectors installed in 2nd floor of day program fish bowl and HR conference room by Simplex Grinnell on 7/24/12. The Facilities Coordinator (Maintenance Supervisor) will assure testing of all smoke detectors per Fire Safety regulations, including 2 year sensitivity testing of all smoke detectors. Any smoke detector that is broken or not functioning properly will be immediately replaced. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/24/2012			

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	<p>Protection Engineer, the second floor day program work room/conference room lacked separation from the corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 18.3.6.1 was not met as follows: the open areas were not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 07/12/12 during the time of observation, with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the above areas were open to the corridor without supervision from the nurses' station and was not protected by automatic smoke detection.</p> <p>3.1-19(b)</p>						

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K0020	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1.</p> <p>An atrium may be used in accordance with 8.2.2.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 vertical openings in the day program section of the facility was enclosed with construction having a fire resistance rating of at least one hour. This deficient practice could affect any client, staff or visitor using the day program south stairwell.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the first floor south day program stairwell door lacked a fire protection rating. Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was</p>	K0020	<p>Building #2: The 1st floor south day program stairwell door is a continuous hinge door. These doors have the fire protection rating on the top of the door. On 7/20/12 the door installer (Door Service Supply) verified that door has a 90 minute fire rating and the rating tag is on top of the door. The Facilities Coordinator will continue to assure that any future doors replaced will meet fire rating requirements. The Facilities Coordinator will present all door replacement orders to the Executive Director prior to order to assure proper fire rating on replacement door.</p>	07/20/2012			

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	<p>acknowledged the first floor south stairwell door lacked a fire rating label and documentation indicating the fire rating of the door was not available.</p> <p>3.1-19(b)</p>			

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K0022	<p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>Based on observation and interview, the facility failed to ensure exit signs were readily visible. This deficient practice could affect any client, staff or visitor in the vocation/education room.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the south exit sign located within the vocation/education room was not readily visible due to a eight foot wall dividing the room. Based on interview on 07/12/12 during the time of observation, with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the south exit sign was not readily visible.</p> <p>3.1-19</p>	K0022	<p>Building #2: An "EXIT" sign visible from all areas of the room was added by WTS Maintenance on 7/20/12. The Facilities Coordinator will assure in minimum of weekly rounds that all exit signs are in proper working order and immediately replace any exit signs damaged / not working properly. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/20/2012			

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K0024	<p>NFPA 101 LIFE SAFETY CODE STANDARD The smoke compartments do not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier does not exceed 200 feet. 18.3.7.1</p> <p>Based on record review and interview, the facility failed to ensure smoke compartments did not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier did not exceed 200 feet. This deficient practice affects clients visitors, or staff using the first floor of the day program corridor.</p> <p>Findings include:</p> <p>Based on review of provided "Fire Safety Features Record Drawings" dated 07/10/2012 on 07/12/12 during record review from 9:45 a.m. to 11:00 a.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the first floor day program corridor identified as Zone 1D measured 28,376 square feet and the travel distance to reach a door in the required smoke barrier was indicated as 292 feet. Based on interview during the tour from 12:15 p.m. to 3:45 p.m., the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer acknowledged the</p>	K0024	The RTM PE consultant has completed a full assessment of the facility (building #2) with recommendations - initial on 7/3/12 and has prepared a FSES document to address K 0024 dated 7/31/12 - attached.	07/31/2012			

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	zone exceeded the allowable square footage and travel distance. 3.1-19(b)			

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K0033	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) in buildings four stories or more are enclosed with construction having fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 vertical openings in the day program section of the facility was enclosed with construction having a fire resistance rating of at least one hour. This deficient practice could affect any client, staff or visitor using the day program south stairwell.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, the first floor south day program stairwell door lacked a fire protection rating. Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the first floor south stairwell door lacked a fire rating label</p>	K0033	<p>Build. #2: The first floor south day program stairwell door is a continuous hinge door. These continuous hinge doors have the fire protection rating on the top of the door. On 7/20/12 the door installer (Door Service Supply) verified that the door has a 90 minute fire rating and the rating tag is in place on top edge of the door. The Facilities Coordinator will continue to assure that any future doors replaced will meet the fire rating requirements. The Facilities Coordinator will present all door replacement orders to the Executive Director prior to order to assure proper fire rating on replacement door.</p>	07/20/2012			

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	and documentation indicating the fire rating of the door was not available. 3.1-19(b)			

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K0053	<p>NFPA 101 LIFE SAFETY CODE STANDARD An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barriers or horizontal exit doors in the corridor.) Such detectors are electronically interconnected to the fire alarm system. 18.3.4.5.3</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 corridors had smoke detectors installed in all corridors of limited care facilities. This deficient practice could affect all clients, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 07/12/12 during a tour from 12:15 p.m. to 3:45 p.m. with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, corridor smoke detection was not provided on the first and second floor of the day program building. Additionally, the second floor staff corridor lacked smoke protection. Based on interview on 07/12/12 during the time of observation with the Executive Director, the Maintenance Supervisor, and a contracted Fire Protection Engineer, it was acknowledged the day program building lacked automatic smoke detection in the</p>	K0053	<p>Building #2:) Smoke detectors were installed in the 1st & 2nd floor corridors of day program building and in the 2nd floor three staff corridors of the day program building by Simplex Grinnell on 7/24/12. The Facilities Coordinator (Maintenance Supervisor) will assure testing of all smoke detectors per Fire Safety regulations, including 2 year sensitivity testing of all smoke detectors. Any smoke detector that is broken or not functioning properly will be immediately replaced. The Facilities Coordinator will present all findings to Executive Director and Quality Assurance Committee to be reviewed monthly.</p>	07/24/2012			

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