

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2015
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NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/16/15</p> <p>Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090</p> <p>At this Life Safety Code survey, Waterford Place Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The original building (1) consisting of 100, 200, 300, 400 and 600 halls was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>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, hard wired smoke detectors</p>	K 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance. Waterford Place Health Campus respectfully requests Desk Review/Paper Compliance.	

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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K 0038 SS=E Bldg. 01	<p>resident sleeping rooms and spaces open to the corridors. The kitchen was located on the assisted living side separated from the rest of the facility with a two hour fire wall. The facility has a capacity of 103 and had a census of 72 at the time of this survey.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 4 delayed egress locks met all conditions of LSC 7.2.1.6.1 so it would be readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that:</p> <p>(a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance</p>	K 0038	<p>1. No residents were affected. 2. All doors with delayed egress locks were inspected to ensure they met all conditions of LSC 7.2.1.6.1 so to be readily available for all residents, staff, and visitors. 3. An audit of all doors with delayed egress locks will be performed weekly by the Director of Plant Services (DPO) or his designee. This audit will be added to the DPO's weekly audit checklist. The doors will be inspected to ensure the sensitivity adjustment is set appropriately to ensure proper operation. 4. The DPO or his Designee will present the findings of these weekly audits at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will determine continuation or revisions to the review process. 5. 7/6/15</p>	07/06/2015

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	<p>with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.</p> <p>(b) The doors unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS</p> <p>This deficient practice could affect 8 residents on 600 hall as well as staff and</p>			

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K 0046 SS=E Bldg. 01	<p>visitors.</p> <p>Findings include:</p> <p>Based on observations on 06/16/15 at 2:30 p.m. with the Maintenance Supervisor the exit door leading out of 600 hall was provided with delayed egress locks with a sign stating "Push the door with open in fifteen seconds", but the exit door did not release. Based on interview concurrent with the observation, it was acknowledged by the Maintenance Supervisor the aforementioned exit door did not meet condition (c) which would ensure the door would open in fifteen seconds as the sign stated on the door.</p> <p>3.1-19(b)</p> <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 7 of 11 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 54 residents as well as staff and visitors if the occupants in the facility</p>	K 0046	<p>1. No residents were affected.</p> <p>2. All exits were inspected to ensure that exterior emergency lighting was provided in order to meet the requirements of LSC 7.9.1.1 so to be available for all residents, staff, and visitors for exit access and exit discharge in the event of an emergency. This inspection was performed by means of complete power down</p>	07/08/2015

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K 0070 SS=E Bldg. 01	<p>were required to evacuate in an emergency.</p> <p>Findings include:</p> <p>Based on observations on 6/16/15 during the tour between 12:59 p.m. to 2:00 p.m. with the Maintenance Supervisor the lighting, emergency or otherwise for seven exits which discharge out of 100 hall, 200 hall, front entrance, 400 hall west and south, 500 hall and 600 hall could not be verified to be on battery or generator backup power. Based on interview on 6/16/15 concurrent with the observations with the Maintenance Supervisor it was acknowledged the aforementioned exits could not be verified to provide lighting for exit discharge during a power outage.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space</p>			K 0070	<p>with only utilization of the generator in order to inspect the exterior emergency lighting and confirm it was functioning as required by LSC 7.9.1.1. 3. An audit will be performed monthly by the Director of Plant Services (DPO) or his designee. This audit will be added to the DPO's monthly audit checklist. The audit will consist of a complete power down with only utilization of the generator in order to ensure all exterior emergency lighting is functioning properly. 4. The DPO or his Designee will present the findings of these monthly audits at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will determine continuation or revisions to the review process. 5. 7/8/15</p> <p>1. No residents were affected. 2. The space heater identified was removed from the reception office. All non resident areas</p>		07/06/2015

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K 0143 SS=E Bldg. 01	<p>heaters observed in nonresident rooms. This deficient practice could affect any resident on Administrative hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/16/15 at 11:05 a.m. with the Maintenance Supervisor, one portable space heater was plugged in and in use in the front Receptions office adjacent to the Administrative hall. Based on interview on 06/16/15 concurrent with the observation, it was acknowledged by the Maintenance Supervisor the space heater was not allowed in the facility.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not</p>				<p>were inspected to ensure no other space heaters were in use.</p> <p>3. An audit of all non resident areas will be performed monthly by the Director of Plant Services (DPO) or his designee to ensure no space heaters are in use. This audit will be added to the DPO's monthly audit checklist. 4. The DPO or his Designee will present the findings of these monthly audits at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will determine continuation or revisions to the review process.</p> <p>5. 7/6/15</p>		

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K 0147 SS=B Bldg. 01	<p>permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transfer occurs had continuously working electrically powered mechanical ventilation. This deficient practice could affect 8 residents on 300 hall as well as visitors and staff in the area.</p> <p>Findings include:</p> <p>Based on observation on 06/16/15 at 2:06 p.m. with the Maintenance Supervisor, the 300 hall oxygen storage room used to store and transfer oxygen was not provided with a working electrically powered mechanical vent. Based on interview on 06/16/15 at 2:08 p.m. it was acknowledged by the Maintenance Supervisor this room was used to transfer oxygen and did not have an electrically powered vent in the room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in</p>	K 0143	<p>1. No residents were affected. 2. The electrically powered vent fan was replaced. All oxygen storage rooms were inspected to ensure all rooms had continuously working electrically powered mechanical ventilation. 3. An audit of all oxygen storage rooms will be performed weekly by the Director of Plant Services (DPO) or his designee to ensure all rooms have continuously working electrically powered mechanical ventilation. This audit will be added to the DPO's weekly audit checklist. 4. The DPO or his Designee will present the findings of these weekly audits at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will determine continuation or revisions to the review process. 5. 7/6/15</p>	07/06/2015

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K 0000 Bldg. 02	<p>accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 ground fault interrupter (GFI) outlets would trip when the test button was engaged. This deficient practice could affect 8 residents in the break room on Center hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/16/15 at 2:30 p.m. a GFI outlet located above the sink in the break room on center hall would not trip when the test button was engaged. Based on interview on 06/16/15 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the GFI would not trip when the test button was engaged.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p>	K 0147	<ol style="list-style-type: none"> 1. No residents were affected. 2. The Ground Fault Interrupter (GFI) outlet identified was replaced. A complete campus audit of all GFI was performed to ensure all GFI outlets functioned properly. 3. An audit of all GFI outlets will be performed monthly by the Director of Plant Services (DPO) or his designee to ensure all GFI are functioning properly. This audit will be added to the DPO's monthly audit checklist. 4. The DPO or his Designee will present the findings of these monthly audits at the Campus Quality Assurance meeting monthly for three months at which time the QA committee will determine continuation or revisions to the review process. 5. 7/6/15 	07/06/2015
		K 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the accuracy or validity of the findings as alleged or conclusion set forth	

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	<p>Survey Date: 06/16/15</p> <p>Facility Number: 002667 Provider Number: 155678 AIM Number: 200300090</p> <p>At this Life Safety Code survey, The Legacy at Waterford Place Health Campus was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. Rooms 201 to 208 on 200 hall of the new building (2) which is open to the rest of the Legacy building was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>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, spaces open to the corridors and hard wired smoke detectors in all resident rooms. The facility has a capacity of 103 and had a census of 72 at the time of this survey.</p>		<p>in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. Please accept this Plan of Correction as Waterford Place Health Campus' Credible Allegation of Compliance. Waterford Place Health Campus respectfully requests Desk Review/Paper Compliance.</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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