

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/25/12</p> <p>Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Clifty Falls was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), 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 one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and single battery operated smoke detectors in</p>	K0000		

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>all resident sleeping rooms. The facility has a capacity of 138 and had a census of 105 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the open wall metal smoking building, the gazebo, the fifteen foot by ten foot storage shed and the twenty foot by fifteen foot storage shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/29/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire door was in accordance with NFPA 80 for 1 of 12 hazardous areas. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient</p>	K0029	<p>The filing of this plan of correction does not constitute an admission that the alleged deficient practice did in fact exist. This plan of correction is filed as evidence of the desire to comply with the regulation and to comply with quality care. This facility further respectfully requests a desk review for paper compliance based on the evidence enclosed.</p> <p>K-029</p> <p>The facility's intent is to ensure applicable doors are self-closing in accordance with NFPA 101 Life Safety Code Standards.</p> <p>A. ACTIONS TAKEN:</p>	11/12/2012	

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	<p>practice could affect 80 residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 10/25/12 at 11:45 a.m. with the maintenance supervisor, the rolling fire door protecting the opening from the kitchen to the main dining room lacked an attached inspection tag. The main dining room was open to the corridor. Based on interview on 10/25/12 and subsequent Fire Safety record review at 10:10 a.m. with the administrator and maintenance supervisor, it was acknowledged there was no documentation of an annual inspection or test to check for proper operation and full closure of the kitchen vertical rolling fire door.</p> <p>3.1-19(b)</p>		<p>1. The rolling kitchen door was inspected on 11/8/12. See Exhibit B</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. 80 residents would have the potential to be affected however no one has been negative affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. The rolling kitchen door has been added to the annual maintenance inspection calendar. See Exhibit A.</p> <p>D. HOW MONITORED:</p> <p>1. The Maint. Director. /Designee will monitor for compliance by reviewing the annual preventative maintenance calendar. See Exhibit A.</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting</p>		

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			with the Medical Director. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 11/12/12.		

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to maintain a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect 58 residents who reside on the 200 Short Hall, 100 Hall and 300 Hall if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observations on 10/25/12 during the tour of the facility from 10:10 a.m. to 2:15 p.m. with the maintenance</p>	K0062	<p>K-062</p> <p>The facility's intent is to ensure that the facility maintains a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 101 Life Safety Code Standards.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Two spare sprinklers were obtained 11/9/12. See Exhibit C</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. All residents would have the potential to be affected however no one has been negative affected.</p> <p>C. MEASURES TAKEN:</p>	11/09/2012			

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	<p>supervisor, red liquid filled ordinary rated pendant sprinklers with a temperature rating of 165 degrees F were observed in the 200 Short Hall corridor, the 100 Hall, and the 300 Hall. Based on observation of the spare sprinkler cabinet located in resident room 114 closet on 10/25/12 at 1:45 p.m. with the maintenance supervisor, there were no red liquid filled pendant sprinklers in the spare sprinkler cabinet. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 2:15 p.m. exit conference on 10/25/12.</p> <p>3.1-19(b)</p>		<p>1. Monitoring to ensure that an minimum of 2 spare sprinkler heads are maintained has been added to the Quarterly preventative maintenance inspection calendar. See Exhibit D.</p> <p>D. HOW MONITORED:</p> <p>1. The Maint. Dir. /Designee will monitor for compliance by reviewing preventative maintenance calendar. See Exhibit D.</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/09/12.</p>	

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K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 8 of 23 portable fire extinguishers was installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect 12 residents who reside on the 200 South Short Hall, 26 residents who reside on the 200 Long Hall, and 6 residents who reside on the 200 Short Hall.</p> <p>Findings include:</p> <p>Based on observations on 10/25/12 during a tour of the facility from 10:10 a.m. to 2:15 p.m. with the maintenance supervisor, the fire extinguishers located in the laundry room, the 200 Short Hall, the two fire extinguishers in the 200 South Short Hall, the 200 Long Hall, and the 200 Hall nurses' station measured between sixty six inches and seventy two inches from the top of the extinguisher to the floor. This was verified by the</p>	K0064	<p>K-064</p> <p>The facility's intent is to ensure that the facility maintains the location of fire extinguishers in accordance with NFPA 101 Life Safety Code Standards.</p> <p>A. ACTIONS TAKEN:</p> <p>1. 8 of 23 fire extinguishers were lowered to the appropriate height of no more than five feet 11/12/12. See Exhibit F.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. All residents would have the potential to be affected however no one has been negative affected.</p> <p>C. MEASURES TAKEN:</p>	11/12/2012			

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	<p>maintenance supervisor at the time of observation and confirmed by the administrator at the 2:15 p.m. exit conference on 10/25/12.</p> <p>3.1-19(b)</p>		<p>1. Monitoring to ensure that fire extinguishers are at the proper height has been added to the monthly preventative maintenance inspection calendar. See Exhibit E.</p> <p>D. HOW MONITORED:</p> <p>1. The Maint. Dir. /Designee will monitor for compliance by reviewing preventative maintenance calendar monthly. See Exhibit E.</p> <p>2. The Adm. /Designee will review all results of audits at the monthly QA meeting with the IDT; and at the quarterly QA meeting with the Medical Director.</p> <p>E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is:</p> <p>11/12/12.</p>		