STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155255	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODVIEW A WATERS COMMUNITY	3420 EAST STATE BLVD FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	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). Survey Date: 02/11/15 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490 Surveyor: Thomas Forbes, Life Safety Code Specialist At this Life Safety Code survey, Woodview A Waters Community 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) and 410 IAC 16.2. The original building consisting of the Skilled hall, the North hall, the South hall, the Southwest hall and the main Dining room and Kitchen was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was	K010000	000 This plan of correction is to serve as Woodview-A Waters Community allegation of compliance. Preparation and/or execution of the plan of correction in general or this corrective action in particular does not constitute an admissions agreement by th facility of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. Woodview-A Waters Community is one building and one licensed facility, however, this survey reflects a description in the report of "two buildings", based on year of added on wing, the surveyor's seperation of building has resulted in appearance of double tags	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER WOODVIEW A WATERS COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3420 EAST STATE BLVD FORT WAYNE, IN 46805	

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	fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and seven resident rooms on the Rehabilitation Hall. The remaining 57 resident rooms had battery operated smoke detectors. The facility has a capacity of 118 and had a census of 90 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 by Dennis Austill, Life Safety Code Specialist on 02/25/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010025 SS=E	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			

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	1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 5 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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 three of six smoke compartments. Findings include: Based on observations with Administrator and the Maintenance Director on 02/011/15 from 1:21 p.m. to 1:50 p.m., the flowing penetrations were noted: a. in the attic a one and a half inch unsealed penetration around data cables through the north skilled unit smoke wall. b. in the attic a one inch unsealed penetration around data cables through the rehab smoke wall.	K010025	K-025- It is the practice of Woodview A Waters Community to ensure penetrations caused by the passage of wire and/or conduit through smoke barrier walls are filled to maintain the smoke resistance of each smoke barrier. To ensure the life safety code standard is met, the following penetrations will be filled with a material capable of maintaining the smoke resistance of the smoke barrier. (Exhibit 1) In building 04, . The attic around data cables in the rehab smoke wall. 2. The noted areas in the Social Service office. 3. The drywall patch in the ceiling of the maintenance office. No Residents were affected by the deficient practice. To prevent future openings around new construction or installation work, the Maintenance Director will be required to observe the work location, type work completed, and ensure there are no open penetrations, and close/fill the penetrations as necessary. The Maintenance Director will document observation and document that any open penetrations have been closed to ensure smoke resistance of smoke barrios (Exhibit 2). The Quality Assurance Committee (QA) will be responsible for oversight of the Maintenance Director's compliance with closure of penetrations following contracted work. The QA Committee will review monthly,	03/13/2015

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	Based on interview, the measurements were provided by the Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect two of six smoke compartments Findings include: Based on observations with Administrator and the Maintenance Director on 02/011/15 from 11:40 a.m. to 12:50 p.m., the flowing penetrations were noted: a. six unsealed penetration measuring one inch to one fourth of a inch around wires and conduits through ceiling of the Social Services office. b. a one inch by four inch unsealed penetration caused by a drywall patch separating form the ceiling in the maintenance office. Based on interview, the measurement were provided by the Maintenance Director at the time of observation.		on an ongoing basis.	

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	3.1-19(b)			
K010029 SS=E	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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 laundry rooms, a hazardous area, was provided with a self closer and would latch into the frame. This deficient practice could affect 14 residents in the ICF-South Hall. Findings include: Based on observation with the Administrator and the Maintenance Director on 02/11/15 at 12:38 p.m., the door entering the laundry room latched into the door frame but did not self close due to the lack of a self closing device. Based on interview, this was acknowledged by the Administrator and the Maintenance Director at the time of	K010029	K029- It is the practice of Woodview-A Waters Community to ensure all doors with automatic closures close and latch securely and properly into the door frame in areas of possible hazards near exits. No Residents were affected by the deficient practice. To ensure the life safety code is met: A. A self closing device was purchased and installed on the door leading to the laundry room. (Exhibit 1) The laundry room door closure will be checked on a monthly basis by the maintenance department to ensure the door closes and latches securely into the door frame. (Exhibit 3) B. The following penetrations will be filled with a material capable of maintaining the smoke resistance of the smoke barrier. (Exhibit 1) 1. ICF North hall janitor closet. 2.	03/13/2015

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	observation. 3.1-19(b) Based on observation and interview, the facility failed to ensure the ceiling provided a smoke resistive barrier in 2 of 2 hazardous areas such a hot water furnace room. This deficient practice could affect 19 residents in the ICF-north hall. Findings include: Based on observations with Administrator and the Maintenance Director on 02/011/15 from 11:30 a.m. to 11:45 p.m., the following was noted: a. in the ICF-north hall janitor/furnace closet there was a one eighth of an inch unsealed penetration around a pipe through ceiling. Also, there was three penetrations covered with drywall tape or silicone, a non approved sealant for smoke resistance. b. in the break room furnace closet there was six unsealed penetrations measuring one inch to one fourth of a inch around wires, pipes, and conduits through the ceiling. Based on interview, the measurement were provided by the Maintenance Director at the time of observation.		Break room furnace closet. To prevent future penetrations, contractors performing work which could cause penetrations, will exit with the maintenance Director, and the Maintenance Director will ensure any open penetrations are filled to maintain smoke resistance (Exhibit 2). The Quality Assurance Committee (QA) will be responsible for oversight of the Maintenance Director's compliance with inspection of Laundry room door and inspections of penetrations following construction/installations. The QA Committee will review monthly, on an ongoing basis.	

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	3.1-19(b)			
K010062 SS=E	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 1. Based on observation and interview, the facility failed to replace 1 of 2 sprinklers in the ICF-north hall shower room which had been painted. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 16 residents in the ICF-North hall. Findings include: Based on observation during a tour with the Administrator and the Maintenance Director on 02/12/15 at 10:40 a.m., one of two automatic sprinklers in the ICF-north hall shower room had paint on the fusible link. Based on interview, this was acknowledge by the Administrator	K010062	K062- It is the practice of Woodview A Waters Community to ensure Automatic Sprinkler Systems are continuously maintained in reliable operating condition and are inspected. To meet the life safety code standard, 2 Sprinklers in ICF North hall shower room have been replaced, (Exhibit 4). In room 112 this is now flush to the ceiling. No Residents were affected by the deficient practice. All Sprinklers have been inspected for dust and escutcheons. (Exhibit 5) Sprinklers will be checked and cleaned on a monthly basis by the maintenance department to ensure sprinklers are maintained in reliable operating condition. (Exhibit 3). The Quality Assurance Committee (QA) will be responsible for oversight of the Maintenance Director's compliance with inspection of sprinkler heads. The QA Committee will review monthly, on an ongoing basis	03/13/2015

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	and the Maintenance Director at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to clean and maintain 3 of 21 sprinklers in the skilled dining room. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect 23 residents using the skilled dining room. Findings include: Based on observation during a tour with the Administrator and the Maintenance Director on 02/11/15 at 11:15 a.m., 3 of 21 automatic sprinklers in the skilled dining room where completely covered in dust. Based on interview, this was acknowledge by the Administrator and the Maintenance Director at the time of observation. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 2 sprinklers in the ICF-north hall and 1 of 2			

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	sprinklers in room 112 were properly maintained. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect 16 residents in the ICF-North hall and 23 residents in the skilled hall. Findings include: Based on observations with the Administrator and the Maintenance Director on 02/11/15 between 10:40 a.m. and 11:15 a.m. , two sprinkler head escutcheons, one in the north show room and one in room 112 had sprinkler, had escutcheons not flush to the ceiling leaving a one quarter inch to one half inch gap into the attic above. Based on interview, this was acknowledge by the Administrator and measurements were provided by the Maintenance Director at the time of observation. 3.1-19(b)			
K010147 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2			

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	Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as a power strip were not used as a substitute for fixed wiring to provide power for high current draw electrical equipment. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect staff using the break room. Findings include: Based on observation with the Administrator and the Maintenance Director on 02/11/15 at 11:45 a.m., an extension cord power strip located in the employee break room provided power to a microwave oven and a coffee pot. Also, that same power strip had another power strip plugged into it providing power to a refrigerator. Based on Interview, this was acknowledged by the Administrator and the Maintenance Director at the time of observations. 3.1-19(b)	K010147	K147 It is the practice of Woodview-A Waters Community to ensure power strips are not used as a substitute for fixed wiring to provide for high current draw. To ensure the regulation is met, the extension power strip was removed and the employee break room was rearranged so the microwave, coffee pot and refrigerator have their own power outlets. No Residents were affected by the deficient practice. The Maintenance Director/designee will randomly check building locations, monthly and document inspections of ensuring power strips are used properly (attachment 3). The Quality Assurance Committee (QA) will be responsible for oversight of the Maintenance Director's compliance with random audits/for proper use of power strips. The QA Committee will review compliance monthly, on an ongoing basis.	03/13/2015
K040000				

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	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). Survey Date: 02/11/15 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490 Surveyor: Thomas Forbes, Life Safety Code Specialist At this Life Safety Code survey, Woodview A Waters Community 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) and 410 IAC 16.2. The new section of the building consisting of the Rehabilitation hall and the Therapy gym was surveyed with Chapter 18, New Health Care Occupancies. 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	K040000	000 This plan of correction is to serve as Woodview-A Waters Community allegation of compliance. Preparation and/or execution of the plan of correction in general or this corrective action in particular does not constitute an admissions agreement by th facility of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. Woodview-A Waters Community is one building and one licensed facility, however, this survey reflects a description in the report of "two buildings", based on year of added on wing, the surveyor's seperation of building has resulted in appearance of double tags	

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	seven resident rooms on the Rehabilitation Hall. The remaining 57 resident rooms had battery operated smoke detectors. The facility has a capacity of 118 and had a census of 90 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 by Dennis Austill, Life Safety Code Specialist on 02/25/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K040025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3 Based on observation and interview, the	K040025	K-025- It is the practice of	03/13/2015

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	facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 smoke barrier wall was protected to maintain the smoke resistance of each smoke barrier. LSC Section 18.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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 13 residents in the Rehabilitation hall. Findings include: Based on observations with Administrator and the Maintenance Director on 02/011/15 from 1:21 p.m. to 1:50 p.m., in the attic there was a one inch unsealed penetration around data cables through the rehab smoke wall. Based on interview, the measurements were provided by the Maintenance Director at the time of observation. 3.1-19(b)		Woodview A Waters Community to ensure penetrations caused by the passage of wire and/or conduit through smoke barrier walls are filled to maintain the smoke resistance of each smoke barrier. To ensure the life safety code standard is met, the following penetrations will be filled with a material capable of maintaining the smoke resistance of the smoke barrier. (Exhibit 1) In building 04, . The attic around data cables in the rehab smoke wall. 2. The noted areas in the Social Service office. 3. The drywall patch in the ceiling of the maintenance office. No Residents were affected by the deficient practice. To prevent future openings around new construction or installation work, the Maintenance Director will be required to observe the work location, type work completed, and ensure there are no open penetrations, and close/fill the penetrations as necessary. The Maintenance Director will document observation and document that any open penetrations have been closed to ensure smoke resistance of smoke barrios (Exhibit 2). The Quality Assurance Committee (QA) will be responsible for oversight of the Maintenance Director's compliance with closure of penetrations following contracted work. The QA Committee will review monthly, on an ongoing basis.	

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