

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155183	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2055 HERITAGE DR MARTINSVILLE, IN 46151
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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: 09/04/15</p> <p>Facility Number: 000096 Provider Number: 155183 AIM Number: 100290890</p> <p>At this Life Safety Code survey, The Waters of Martinsville 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 (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detection in all resident sleeping rooms. The facility has a capacity of 103 and had a census of 82 at</p>	K 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The Waters of Martinsville respectfully requests paper compliance for these citations.</p>	
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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 0025 SS=E Bldg. 01	<p>the time of this visit.</p> <p>All areas where residents have customary access were sprinklered except for one detached smoking shed with customary access for resident smokers. The facility has one detached storage shed providing facility storage services which was not sprinklered.</p> <p>Quality Review completed 09/10/15 - DA</p> <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 2 of 6 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier</p>	K 0025	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	10/04/2015

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	<p>or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 44 residents, staff and visitors in the vicinity of the smoke barrier wall by Room 27 and by the Maintenance Office.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 09/04/15, the following was noted in the attic smoke barrier wall by Room 27 and by the Maintenance Office:</p> <p>a. the three inch annular space surrounding a two inch in diameter PVC pipe and a six inch in diameter hole for the passage of eight data cables was noted in the attic smoke barrier wall above the corridor door set by Room 27.</p> <p>b. two one inch in diameter holes and a two inch in diameter hole for the passage of cables was noted in the attic smoke barrier wall above the corridor door set by the Maintenance Office.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the openings in the aforementioned attic smoke barrier wall did not maintain the fire resistance rating of the smoke barrier wall.</p>		<p>The Waters of Martinsville respectfully requests paper compliance for this citation.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The 2 noted openings in the smoke barrier walls were filled with fire proof caulk to ensure the integrity of the smoke barrier.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>All residents had the potential to be affected. An audit of all smoke barrier walls were completed to ensure the integrity of the smoke barrier walls throughout the entire facility. No other compromised areas were noted or identified.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p>	

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	3.1-19(b)		<p>At the completion of any vendor work that occurs in which demolition is involved, the maintenance director will inspect the area of work completed, and then note and correct any defective areas in the smoke barrier walls. The results will be maintained in the Maintenance supervisor's office with a copy of the scope of work. Once the maintenance supervisor has reviewed the area of work, the maintenance assistant will perform a visual inspection separately and initial on the paperwork that any compromised areas in the smoke barrier have indeed been repaired.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i></p> <p>Once the maintenance supervisor has reviewed the area of work, the maintenance assistant will perform a visual inspection and initial on the paperwork that any compromised areas in the smoke barrier have indeed been repaired. Any missed areas will be corrected immediately, and the discrepancy will be communicated to the Maintenance Supervisor and the Administrator. The results of these audits will be reviewed by the administrator within 48 hours of the work being</p>	

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K 0047 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on record review, observation and interview; the facility failed to ensure 1 of 1 doors likely to be mistaken for a way of exit was identified with a sign reading, " No Exit " . LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads: " NO Exit " . This deficient practice could affect 30 residents, staff and visitors in the Dining Room.</p> <p>Findings include:</p> <p>Based on review of the facility's floor plan documentation during record review with the Maintenance Director and the Maintenance Assistant from 9:20 a.m. to 11:35 a.m. on 09/04/15, the east door of the Dining Room which leads to the outside of the building is marked as a</p>	K 0047	<p>completed, and will initial the paperwork verifying any compromised areas have indeed been repaired. Results will be maintained in the Maintenance Supervisor's office.</p> <p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>The Waters of Martinsville respectfully requests paper compliance for this citation.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affect ted by the deficient practice?</i></p> <p>An 8 x 10 Sticker stating "Not an Exit" has been placed at eye level on</p>	10/04/2015

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	<p>facility exit. Based on observation with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 09/04/15, the east door of the Dining Room which leads to the outside of the building is not marked with a facility exit sign. The door was magnetically locked and could be opened by entering a four digit code but the code was not posted. The east door of the Dining Room which leads to the outside of the building was not equipped with a sign stating "NO exit." Based on interview at the time of observation, the Maintenance Director stated the east door of the Dining Room which leads to the outside of the building is not a facility exit and acknowledged it was not equipped with a sign stating, "NO Exit."</p> <p>3.1-19(b)</p>		<p>the side of the door facing the Main Dining Hall.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>All residents that dine in the main dining hall had the potential to be affected. An 8 x 10 Sticker stating "Not an Exit" has been placed at eye level on the side of the door facing the Main Dining Hall.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>An 8 x 10 Sticker stating "Not an Exit" has been placed at eye level on the side of the door facing the Main Dining Hall.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i></p>	

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K 0062 SS=F Bldg. 01	<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 record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Service Call Report" documentation during record review with the Maintenance Director and the Maintenance Assistant from 9:20 a.m. to 11:35 a.m. on</p>	K 0062	<p>An audit of the current floor plan was conducted to ensure there were no other doors with incorrect or non-existent signage. None were identified. The floor plan was updated to reflect the current and proper exits located throughout the facility.</p> <p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>The Waters of Martinsville respectfully requests paper compliance for this citation.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affect ted by the deficient practice?</i></p>	10/04/2015

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	<p>09/04/15, an internal pipe inspection conducted on 07/02/14 for the facility's sprinkler system stated "Performed Internal Pipe inspection on fire sprinkler system. Found that 2.5 inch cross main above Room 19 and 20 and 2.5 inch cross main above Dining Room is full of rust and debris. Recommend that sprinkler system be flushed. Send quote to flush fire sprinkler system." Based on interview at the time of record review, the Maintenance Director stated sprinkler system flushing had not been performed since SafeCare's internal pipe inspection and acknowledged sprinkler system flushing has not been performed or scheduled on or after 07/02/14.</p> <p>3.1-19(b)</p>		<p>A waiver for the scope of work is being requested. The impending freezing temperatures will prohibit the sprinkler flush as there is too much risk of having water freeze in the system, potentially compromising the system. The monthly system flushes have been completed, as well as the inspections verifying the sprinkler system is operating as it should. Once the weather is conducive to the extent of the complete system flush, it will be completed. The completion date will be no later than June 2016.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>All residents have the potential to be affected. However, the monthly system flushes have been completed, as well as the inspections verifying the sprinkler system is operating as it should. Once the weather is conducive to the extent of the complete system flush, it will be completed. The completion date will be no later than June 2016.</p>	

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			<p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The monthly system flushes have been completed, as well as the inspections verifying the sprinkler system is operating as it should. Once the weather is conducive to the extent of the complete system flush, it will be completed. The completion date will be no later than June 2016. This system flush is required every 5 years, and will be tracked and maintained in the Maintenance Supervisor's preventative maintenance log, as well as in the Administrator's office.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i></p> <p>This system flush is required every 5 years, and will be tracked and maintained in the Maintenance Supervisor's preventative maintenance log, as well as in the Administrator's office. Monthly inspections and flushes will continue until the weather is appropriate for the large scale flush to ensure there is no risk to residents and the sprinkler system is operating as it should. The large scope system</p>	

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K 0064 SS=E Bldg. 01	<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>1. Based on observation and interview, the facility failed to ensure 1 of 17 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect ten residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 09/04/15, the inspection tag affixed to the portable fire extinguisher in the attic access room by Room 27 indicated</p>			K 0064	<p>flush will occur no later than June of 2016.</p> <p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>The Waters of Martinsville respectfully requests paper compliance for this citation.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affect ted by the deficient practice?</i></p> <p>The fire extinguisher identified that had not been inspected for proper working condition was replaced with a fully charged fire extinguisher. An inspection tag was placed on the</p>		10/04/2015

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	<p>February 2012 as the date the most recent annual maintenance was performed. Based on interview at the time of observation, the Maintenance Director stated no other annual fire extinguisher maintenance documentation was available for review and acknowledged the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve month period.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to inspect 1 of 17 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect ten residents, staff</p>		<p>extinguisher verifying it is in proper working condition and fully operational.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>10 Residents residing on the south end of the building had the potential to be affected. The fire extinguisher identified that had not been inspected for proper working condition was replaced with a fully charged fire extinguisher. An inspection tag was placed on the extinguisher verifying it is in proper working condition and fully operational.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The updated floor plan reflects the location of the missed fire extinguisher as well as the location of all fire extinguishers in the building. This floor plan will be used as the monthly guide for the preventative maintenance inspections. Once the maintenance supervisor has inspected all fire</p>	

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K 0067 SS=F Bldg. 01	<p>and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 09/04/15, the inspection tag affixed to the portable fire extinguisher in the attic access room by Room 27 indicated a monthly inspection was not documented after September 2012. Based on interview at the time of observation, the Maintenance Director stated no additional documentation of monthly fire extinguisher checks for the attic access room fire extinguisher was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher was not documented after September 2012.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the</p>	K 0067	<p>extinguishers, the maintenance assistant will perform the same inspection separately. Both will initial the inspection tags to ensure the location of every fire extinguisher is known, and they are in proper operating condition.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i></p> <p>At the completion of the monthly inspections by both maintenance personnel, the results will be provided to the Administrator. Utilizing the updated floor plan, the Administrator or his designee shall visually inspect all fire extinguishers. Discrepancies will immediately be corrected, and results of these monthly inspections will be maintained in the administrator's office. The administrator audits will continue for 6 months to ensure ongoing compliance. The dual inspection by both maintenance personnel will be ongoing.</p>	10/04/2015

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NAME OF PROVIDER OR SUPPLIER WATERS OF MARTINSVILLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2055 HERITAGE DR MARTINSVILLE, IN 46151
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	<p>facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 67 of 75 rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 09/04/15, resident rooms and support offices were using the egress corridor as a return air system in all rooms in the facility except for rooms 13, 15, 38, 39, 40, 41 and the Physical Therapy Room in the Comfort Creek short hall. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned resident rooms and support offices were using the egress corridor as a return air system.</p>		<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>The Waters of Martinsville respectfully requests paper compliance for this citation.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affect ted by the deficient practice?</i></p> <p>It is the intent of the facility to ensure that heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. We are requesting the waiver provided last year will again be granted as the cost of the proposed remedy would create a financial hardship. The waiver continuation would not result in affecting the health and safety of our residents. Even though the corridor is used as a plenum, the air handling units are on automatic shutdown when the fire alarm is activated. Further, we have smoke</p>	

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	3.1-19(b)		<p>detectors and dampers in the ductwork that are connected to the fire alarm system that activate and prevent the transfer of smoke in the event the fire alarm is triggered. We have had this waiver in place for the previous 11 years and have not put our residents at risk as a result.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>It is the intent of the facility to ensure that heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. We are requesting the waiver provided last year will again be granted as the cost of the proposed remedy would create a financial hardship. The waiver continuation would not result in affecting the health and safety of our residents. Even though the corridor is used as a plenum, the air handling units are on automatic shutdown when the fire alarm is activated. Further, we have smoke detectors and dampers in the ductwork that are connected to the fire alarm system that activate and prevent the transfer of smoke in the event the fire alarm is triggered. We have had this waiver in place for the</p>	

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			<p>previous 11 years and have not put our residents at risk as a result.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>It is the intent of the facility to ensure that heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. We are requesting the waiver provided last year will again be granted as the cost of the proposed remedy would create a financial hardship. The waiver continuation would not result in affecting the health and safety of our residents. Even though the corridor is used as a plenum, the air handling units are on automatic shutdown when the fire alarm is activated. Further, we have smoke detectors and dampers in the ductwork that are connected to the fire alarm system that activate and prevent the transfer of smoke in the event the fire alarm is triggered. We have had this waiver in place for the previous 11 years and have not put our residents at risk as a result.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient</i></p>	

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K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 2 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA	K 0130	<i>practice will not recur, i.e., what quality assurance program will be put into place?</i> It is the intent of the facility to ensure that heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. We are requesting the waiver provided last year will again be granted as the cost of the proposed remedy would create a financial hardship. The waiver continuation would not result in affecting the health and safety of our residents. Even though the corridor is used as a plenum, the air handling units are on automatic shutdown when the fire alarm is activated. Further, we have smoke detectors and dampers in the ductwork that are connected to the fire alarm system that activate and prevent the transfer of smoke in the event the fire alarm is triggered. We have had this waiver in place for the previous 11 years and have not put our residents at risk as a result. Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the	10/04/2015

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	<p>101, Section 19.1.1.3 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 11:35 a.m. to 1:15 p.m. on 09/04/15, two natural gas fired water heaters installed in the Utility Room by Room 27 identified as Registration #274779 and Registration #236223 each had an expiration date of 04/09/14 listed on the posted Certificate of Inspection documentation from the State of Indiana. Based on interview at the time of the observations, the Maintenance Director stated he was unaware of any recent pressure vessel inspections and acknowledged recent pressure vessel inspection documentation and current Certificate of Inspection documentation for the aforementioned two natural gas fired water heaters was not available for review.</p> <p>3.1-19(b)</p>				<p>facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>The Waters of Martinsville respectfully requests paper compliance for this citation.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The 2 fire fueled water heaters identified without an updated inspection have been inspected, approved, had new pressure vessels installed into each unit and had new certification labels attached verifying their status.</p> <p><i>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p>All residents, staff and visitors had the potential to be affected. The 2 fire fueled water heaters identified without an updated inspection have been inspected, approved, had new pressure vessels installed into each</p>		

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			<p>unit and had new certification labels attached verifying their status.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>Annually, the maintenance supervisor will have all fire fueled water heaters inspected. The inspections will be added to the preventative maintenance log, and reviewed by the maintenance director monthly. The certificate of inspection will be maintained in the preventative maintenance log, and will separated by month to be able to identify when inspections with longer intervals between are completed.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</i></p> <p>Monthly, the administrator and the maintenance director will review the monthly preventative maintenance log and review any inspections upcoming or that are due. Any inspections that are required will be scheduled.</p>	