

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  04/22/2014
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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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K010000	<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: 04/22/14</p> <p>Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>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.</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, in areas open to the corridors and in seven resident rooms on the Rehabilitation Hall. The remaining 57 resident rooms had battery operated smoke detectors. The facility has a capacity of 128 and had a census of 100 at the time of this survey.</p>	K010000	000-This Plan of correction is to serve as Woodview-A Waters Community's allegation of 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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K010029 SS=E	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: 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 and interview, the facility failed to ensure the corridor door to 1 of 1 kitchens, a hazardous area, would close and latch securely into the frame. This deficient practice could affect residents evacuated through the ICF nurses' station exit.</p> <p>Findings include:  Based on observation with the Administrator and the Maintenance Director on 04/22/14 at</p>	K010029	<p><b>K 029</b></p> <p>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.</p>	05/22/2014

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	<p>12:07 p.m., the rear kitchen corridor door did self close. but the upper section of the door hit the door frame which prevented the door from closing and latching. At the time of observation, the Maintenance Director acknowledged the kitchen door did not latch into the door frame because the hinges needed replaced.</p> <p>3.1-19(b)</p>		<p>To ensure the Life Safety Code Standard is met, on 05/06/14 a down payment was made to Duhadway Corp to replace the kitchen door. The door will be check on a monthly basis by the maintenance department to ensure the door closes and latches securely into the door frame.</p> <p>The maintenance department will then turn the monthly logs into the corporate compliance officer which then will be reviewed on a quarterly basis at the quality assurance meeting.</p> <p>No residents were affected by the deficient practice.</p> <p>Date of completion: 05/22/2014</p>	

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K010047 SS=E	<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</p> <p>Based on observation, record review and interview; the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was immediately visible for 2 of 7 ways to the exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect residents evacuated through the exit near the ICF nurses' station and 24 residents on the Skilled hall.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director on 04/22/14 at 12:30 p.m. and then again at 1:35 p.m., there was no illuminated exit sign above the exit door near the ICF nurses' station or the exit door in the Skilled hall dining room. The facility evacuation map indicated, and the Administrator confirmed, both exit doors were used for emergency evacuation.</p> <p>3.1-19(b)</p>	K010047	<p>See Attachment A-2 for Duhadway Corp. contract, receipt A-3, and log form A-4.</p> <p><b>K 047</b> It is the practice of Woodview-A Waters Community to ensure safety by using continuously illuminated exit signs for all exit doors that are used for emergency evacuations.</p> <p>To ensure that the Life Safety Code Standard is met, on 05/01/2014 illuminated exit lights were installed by maintenance personnel Brian Rothgeb, over the exit doors near the ICF nurse's station and the Skilled hall.</p> <p>The maintenance department will monitor exit signs on a monthly basis and logs will be submitted to the corporate compliance officer. These logs</p>	05/22/2014			

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K010056 SS=E	<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 ensure a complete automatic sprinkler system was provided for 1 of 1 Southwest hall electrical rooms in accordance with NFPA 13, Standard for the</p>	K010056	<p>will be reviewed on a quarterly basis at the quality assurance meeting.</p> <p>No residents were affected by the deficient practice.</p> <p>Date of completion: 05/22/2014</p> <p>See Attachment A-4 and B-1 for order packing list of illuminated exit signs.</p> <p><b>K 056</b></p> <p>It is the practice of Woodview-A Waters Community to meet Life</p>	05/22/2014

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	<p>Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. Exception: Sprinklers shall not be required where all of the following conditions are met: (a) The room is dedicated to electrical equipment only. (b) Only dry type electrical equipment is used. (c) Equipment is installed in a 2 hour fire rated enclosure including protection for penetrations. (d) No combustibile storage is permitted to be stored in the room. This deficient practice could affect 18 residents on the Southwest hall.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Director on 04/22/14 at 12:40 p.m., the Southwest electrical room lacked sprinkler coverage. The room was constructed of concrete and block with a two hour fire rated corridor door that lacked a self closing device. Based on an interview with the Administrator at the time of observation, she acknowledged the electrical room corridor door lacked a self closing device but thought she met all of the equipments for a dedicated electrical room which is why the room lacked a sprinkler head.</p> <p>3.1-19(b)</p>		<p>Safety Code Standards by maintaining an automatic closure on the door to the electrical room.</p> <p>To ensure that the Life Safety Code Standard is met on 05/06/14, a down payment was made to Duhadway Corp to install an automatic closure on the Southwest electrical room door. The automatic closure door will be checked on a monthly basis by the maintenance department to ensure it is functioning properly. The logs will then be submitted to the corporate compliance officer and be reviewed on a quarterly basis at the quality assurance meeting.</p> <p>No residents were affected by the deficient practice.</p> <p>Date of completion: 05/22/2014</p>	

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review and interview, the facility failed to ensure 3 of 5 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect 2 of 3 smoke compartments.</p> <p>Findings include:</p> <p>Based on record review with the Administrator and the Maintenance Director on 04/22/14 from 12:10 p.m. to 1:32 p.m., the water heaters in the laundry room, the mechanical room located in the breakroom and the Skilled hall water heater room had a Certificate of Inspection that expired on 02/07/14. Based on interview with the Administrator, the inspector had been in the building before the certificates expired but said he would be back to inspect the three water heaters at a later date.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and</p>	K010130	<p>See attachment of Duhadway Corp. contract A- 2, receipt A-3, and log form A-4</p> <p><b>K 130 (1)</b></p> <p>It is the practice of Woodview-A Waters Community to ensure safe operation of all water heaters in the facility. To meet the Life Safety Code Standard, on 04/24/2014 Dean Toor, State Boiler Inspector of Indiana, completed an inspection of all water heaters in the facility.</p> <p>No residents were affected by the deficient practice.</p> <p>On a quarterly basis, the maintenance department will monitor the inspection tags located on the water heaters</p>	05/22/2014

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	<p>interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 57 of 64 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect 2 of 3 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director on 04/22/14 during the tour from 12:00 p.m. to 1:45 p.m., there was a battery operated smoke detector in each of the resident rooms in the existing section of the building. Based on record review at 11:40 a.m., there was no annual battery replacement date on the "Smoke Detector List" form. At the time of record review the Maintenance Director stated, he replaces the battery when the smoke detector emits an audible chirp.</p> <p>3.1-19(b)</p>		<p>to ensure compliance and safety standards are met. The maintenance department will submit the logs to the corporate compliance officer and it will be reviewed by the quality assurance committee quarterly.</p> <p>Date of completion: 05/22/2014</p> <p>See attachment of invoice for inspection C-1, C-2, C-3, copy of check C-4, and log of inspection tags C-5.</p> <p><b>K 130 (2)</b></p> <p>It is the practice of Woodview-A Waters Community to maintain a preventative maintenance program to ensure proper operation of battery operated smoke detectors. On 05/01/2014, the maintenance department put in place a</p>	

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			<p>preventive maintenance program to ensure batteries are functioning properly. Scheduled checks will be conducted and logged on a monthly basis.</p> <p>No residents were affected by the deficient practice.</p> <p>The replacements of batteries will be done on an annual basis by the maintenance department.</p> <p>Maintenance logs will then be submitted to the corporate compliance officer and reviewed by the quality assurance committee on a quarterly basis.</p> <p>See attachment of monthly smoke detector check list schedule D-1, smoke detector check list D-2, D-3, D-4, D-5,</p>	

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K010143 SS=E	<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 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 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 24 resident in Skilled hall.</p> <p>Findings include:  Based on an observation with the</p>	K010143	<p>D-6, and annual battery replacement schedule D-7.</p> <p>Date of completion: 05/22/2014</p> <p><b>K 143</b> It is the practice of Woodview-A Waters Community to ensure safety in all areas where transferring of oxygen occurs. To meet Life Safety Code Standards, on 05/06/14 a down payment was made to Duhadway Corp. to install a fire rated door with a readable tag to the oxygen room. The maintenance department will monitor the fire rated door on the oxygen room every month months to ensure the fire rated</p>	05/22/2014

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K040000	<p>Administrator and the Maintenance Director on 04/22/14 at 1:30 p.m., the oxygen transferring room had a unrated metal corridor door. Based on an interview with the Administrator at the time of observation, she stated the door does not have an attached fire rating tag but it is a steel door.</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> <p>Survey Date: 04/22/14</p> <p>Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully</p>	K040000	<p>tag remains visible. The logs will then be submitted to the corporate compliance officer and reviewed by the quality assurance committee on a quarterly basis. No residents were affected by the deficient practice. Date of completion: 05/22/2014 See attachment A-2, A-3, and A-4.</p> <p>000-This Plan of correction is to serve as Woodview-A Waters Community's allegation of Compliance.</p>	

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	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and in seven resident rooms on the Rehabilitation Hall. The remaining 57 resident rooms had battery operated smoke detectors. The facility has a capacity of 128 and had a census of 100 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p>			