

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 05/20/2013
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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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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: 05/20/13</p> <p>Facility Number: 000096 Provider Number: 155183 AIM Number: 100290890</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</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</p>	K010000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or 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>	

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>rooms. The facility has a capacity of 103 and had a census of 91 at 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>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 05/22/13.</p>				

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation, the facility failed to ensure 1 of 6 sets of smoke barrier doors were equipped with the appropriate hardware to allow the door that must close first, always closes first so that both doors will always close completely as a pair. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors that swing in the same direction and equipped with an astragal to have a coordinator to ensure the door that must close first always closes first. This deficient practice could affect 22 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, the set of corridor smoke barrier doors by Room 27, which</p>	K010027	<p>K027 It is the intent of this facility to ensure smoke barrier doors are equipped with the appropriate hardware to allow the door that must close first, always closes first so that both doors will always close completely as a pair. 1. Action Taken: The set of smoke barrier doors by Room 27 has been repaired by replacing astragal hardware to meet set standards. 2. Others Identified: All fire doors were inspected/tested to meet set standards. 3. Systems in Place: The maintenance supervisor/designee will inspect all smoke barrier doors as part of preventative maintenance program. 4. How Monitored: Inspection reports will be reviewed by the QA committee during quarterly QA meetings.</p>	06/19/2013			

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	<p>swung in the same direction and were equipped with an astragal, lacked a coordinator to allow the astragal side of the door to close last. Based on interview at the time of record review, the Maintenance Director stated the astragal was removed to paint the door frame and acknowledged the set of corridor smoke barrier doors by Room 27 did not have a coordinator to allow the astragal side of the door to close last.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<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>1. Based on observation and interview, the facility failed to ensure 2 of 8 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) states activation of the building automatic sprinkler or fire detection system, if provided, automatically unlocks the doors and the doors remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 22 residents, staff and visitors if needing to exit the facility from the Serenity Cove Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, the electromagnetic lock on the Serenity Cove exit door by Room 1 and by Room 10 each did not release and remain unlocked when the fire alarm was activated at 2:23 p.m. Based</p>	K010038	<p>K038 It is the intent of this facility to ensure that electromagnetic locks remain unlocked while fire alarm is activated. It is also the intent of this facility to ensure that means of egress are readily accessible for residents without a clinical diagnosis requiring specialized security measures. 1. Actions Taken: Licensed contractor tested all electromagnetic locks and will make repairs to meet NFPA 101 standards. The security code was posted by exit door by Room 25. 2. Others Identified: All magnetic locks inspected/tested to meet standards. 3. Systems in Place: Maintenance supervisor/designee will inspect all magnetic locks as part of the preventative maintenance program. 4. How Monitored: Inspection reports will be reviewed by QA committee during quarterly QA meetings.</p>	06/19/2013			

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	<p>on interview at the time of observation, the Maintenance Director acknowledged the electromagnetic lock on the Serenity Cove exit door by Room 1 and by Room 10 each did not release and remain unlocked when the fire alarm was activated.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 22 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the</p>			

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	<p>Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, the skilled unit corridor exit by Room 25 was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview with the Maintenance Director at the time of observation, residents who have a clinical diagnosis to be in a secure building are housed only in a portion of the building in the Serenity Cove Hall and acknowledged the exit code was not posted at the skilled unit corridor exit by Room 25 for use by residents without the clinical diagnosis requiring specialized security measures. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p>						

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K010046 SS=F	<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 record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 14 of 14 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Lighting Log" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:35 a.m. on 05/20/13, the following was noted: a) documentation of an annual ninety minute test for each of fourteen battery operated emergency lights in the facility</p>	K010046	<p>K046 It is the intent of this facility to ensure emergency lighting for at least 1 ½ hour duration. 1. Actions Taken: Proper testing and documentation of all emergency lighting completed to meet NFPA 101 standards. 2. Others Identified: All emergency lighting tested. 3. Systems in Place: Maintenance supervisor/designee will inspect all emergency lighting as part of the preventative maintenance program. 4. How Monitored: Inspection reports will be reviewed by QA committee during quarterly QA meetings.</p>	06/19/2013			

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	<p>for the most recent twelve month period was not available for review.</p> <p>b) functional testing documentation at 30 day intervals for not less than 30 seconds for each of fourteen battery powered emergency lights in the facility for the most recent twelve month period was not available for review.</p> <p>Based on interview at the time of record review, the Maintenance Director acknowledged documentation of an annual ninety minute test for each of fourteen battery operated emergency lights in the facility for the most recent twelve month period was not available for review. In addition, the Maintenance Director stated monthly functional testing as documented in "Emergency Lighting Log" is not a minimum 30 second test for each light and acknowledged functional testing documentation at 30 day intervals for not less than 30 seconds for each of fourteen battery powered emergency lights in the facility for the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, two battery powered emergency lights were observed at each facility exit.</p> <p>3.1-19(b)</p>			

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan for the replacement of battery operated smoke detectors installed in 51 of 51 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector" policy with the Maintenance Director and the Housekeeping Supervisor during record review from 9:10 a.m. to 11:35 a.m. on 05/20/13, Procedure 4 states "If the Battery Operated Smoke Detector passed</p>	K010048	<p>K048 It is the intent of this facility to have a written plan for the protection of all patients and for their evacuation in the event of an emergency. 1. Action Taken: Reviewed and updated "Battery Operated Smoke Detector Policy" and maintenance director/designee inspected all smoke detectors and replaced all outdated batteries and detectors. 2. Others Identified: All smoke detectors and batteries inspected. 3. Systems in Place: Maintenance director/designee will inspect all smoke detectors and batteries and provide appropriate documentation in accordance with updated policy as part of preventative maintenance program. 4. How Monitored: Inspection reports will be reviewed by QA committee during quarterly QA meeting.</p>	06/19/2013

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	<p>the monthly test for a ten year period, at the end of the ten year period, the battery will be replaced and the date recorded directly on the replacement battery and in the Maintenance Department Red Binder". Procedure 6 states "All replacement batteries will be replaced with a ten (10) year Lithium Battery". In addition, "Education Center Overview" documentation for FireX model C battery operated smoke detectors states smoke alarms shall be replaced every ten years. Based on interview at the time of record review, the Maintenance Director stated the aforementioned policy does not include a statement to replace alkaline batteries in smoke detectors annually and acknowledged the policy does not include a statement to replace each smoke detector ten years after its manufacture date. Based on observation with the Maintenance Director and the Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, FireX model C battery operated smoke detectors were installed in each resident sleeping room and were each manufactured in 2005. Alkaline batteries were installed in smoke detectors in resident sleeping rooms 4, 7, 10, 16, 37 and 41.</p> <p>3.1-19(a)</p>			

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to document fire drills conducted on the first shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:35 a.m. on 05/20/13, documentation of a fire drill conducted on the first shift for the third quarter of 2012 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fire drill conducted on the first shift for the third quarter of 2012 was not available for review.</p> <p>3.1-19(b)</p>	K010050	<p>K050 It is the intent of this facility to conduct fire drills at least quarterly on each shift. 1. Action Taken: Reviewed and organized quarterly fire drills and documentation. 2. Others identified: No others identified. 3. Systems in Place: Maintenance director/designee will conduct fire drills at least quarterly on each shift and provide proper documentation. 4. How Monitored: Fire drill logs will be reviewed by QA committee at quarterly QA meeting.</p>	06/19/2013	

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview; the facility failed to ensure 42 of 42 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method</p>	K010052	<p>K052 It is the intent of this facility to have an approved maintenance testing program of fire alarm system complying with applicable requirements of NFPA 70 and 72. 1. Action Taken: Smoke detector sensitivity testing conducted by licensed contractor was conducted of all facility smoke detectors and proper documentation in place. 2. Others Identified: All facility smoke detectors underwent sensitivity testing. 3. Systems in Place: Maintenance director/designee will schedule testing with licensed contractor and maintain documentation in accordance with NFPA 70 and 72. 4. How Monitored: Sensitivity testing logs will be reviewed by quarterly QA committee at quarterly QA meeting.</p>	06/19/2013			

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	<p>(2) Manufacturer's calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and the Housekeeping Supervisor from 9:10 a.m. to 11:35 a.m. on 05/20/2013, smoke detector sensitivity testing documentation for the most recent two year period was not available for review. Annual functional testing of smoke detectors as documented in JA Fire Protection's "Report of Inspection" documentation dated 02/25/13 indicates there are 30 smoke detector and 12 duct detectors hard wired to the fire alarm system in the facility. Based on interview at the time of</p>						

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	<p>record review, the Maintenance Director stated documentation of smoke detector sensitivity testing in the last two years was not available for review and acknowledged it has been more than two years since facility smoke detectors were sensitivity tested.</p> <p>3.1-19(b)</p>			

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K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 1 of 1 outside areas where smoking was permitted. This deficient practice could affect any two residents, staff and visitors in the detached smoking shed.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Supervisor during the tour</p>	K010066	<p>K066 It is the intent of this facility to ensure that cigarette butts are deposited into a noncombustible container with a self-closing lid. Action Taken: Removed combustible plastic container from smoking shed. 2. Others Identified: No others identified. 3. Systems in Place: Maintenance director/designee will make daily rounds of facility grounds to ensure that combustible containers are not in smoking area. This will be an ongoing process. 4. How Monitored: Findings will be</p>	06/19/2013			

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	<p>of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, the resident smoking shed located outside of the facility had one 32 gallon plastic trash can which had combustible waste paper and in excess of twenty cigarette butts disposed of in the trash can. Based on interview at the time of observation, the Maintenance Supervisor acknowledged cigarette butts had been disposed into a combustible plastic container in the resident smoking shed.</p> <p>3.1-19(b)</p>		<p>reviewed in daily morning meeting.</p>	

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K010067 SS=F	<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</p> <p>Based on observation and interview, the 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 Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, resident rooms and support offices were using the egress corridor as a return air system in all rooms in the facility except for rooms 12, 13, 15, 38, 39, 40, 41 and the Physical Therapy</p>	K010067	<p>K067 It is the intent of this facility to ensure that heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacture's specifications. 1. Action Taken: Submitted Safety Code Waiver Request. 2. Others Identified: Waiver encompasses entire facility. See attachments.</p>	06/19/2013			

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	<p>room by Room 12. However, the facility has modified the HVAC (Heating, Ventilation, and Air Conditioning) system so that activation of the fire alarm system will stop the supply air fans.</p> <p>Additionally, the supply air fans have duct detectors located downstream of the air filters that when activated, shut down the fans operation. Finally, smoke dampers interconnected to the fire alarm system were located to prevent the transfer of smoke from one compartment to other smoke compartments. 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>3.1-19(b)</p>			

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K010069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of Vanguard Alarm Services "Periodic Range Hood & Suppression System Testing & Inspection Report" documentation dated 03/12/12 and 02/27/13 with the Maintenance Director during record review from 9:10 a.m. to 11:35 a.m. on 05/20/13, documentation of a semiannual kitchen hood extinguishing system service record after 03/12/12 and prior to 02/27/13 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged a semiannual kitchen hood extinguishing system service record after 03/12/12 and prior to 02/27/13 was not available for</p>	K010069	<p>K069 It is the intent of this facility to ensure cooking facilities are protected in accordance with NFPA 96. 1. Actions Taken: Kitchen hood extinguishing system serviced and inspected as well as provided appropriate documentation. 2. Others Identified: Facility has only one fully equipped kitchen. 3. Systems in Place: Maintenance director/designee scheduled routine service and inspection with licensed contractor. 4. How Monitored: Preventative maintenance logs to be reviewed by quarterly QA committee at quarterly QA meetings.</p>	06/19/2013			

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	review. 3.1-19(b)			

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K010074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure window valences in offices, open areas and resident sleeping rooms in 4 of 7 smoke compartments were flame resistant. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, window valences in the Social Services office and in resident sleeping rooms 13, 18, 42 and 44 and</p>	K010074	<p>K074 It is the intent of this facility to ensure that window valences in offices, open areas, and resident sleeping rooms are flame resistant.</p> <p>1. Actions Taken: An audit of all valences and curtains were conducted. Those without affixed documentation were treated and affixed with documentation. 2. Others Identified: An audit of all window coverings was conducted.</p> <p>3. Systems in Place: Maintenance director/designee will inspect window coverings throughout facility as part of the preventative maintenance program and maintain a log of treated valences and curtains. 4. How Monitored: Maintenance logs will be reviewed</p>	06/19/2013

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	<p>window curtains in the Dining Room had no affixed documentation stating each window valence and curtain was inherently flame retardant. Based on record review with the Maintenance Director and the Housekeeping Supervisor from 9:10 a.m. to 11:35 a.m. on 05/20/2013, window valence and curtain flame retardant documentation was not available for review. Based on interview at the time of record review, the Housekeeping Supervisor stated the aforementioned valences and curtains are treated with a flame retardant material but acknowledged documentation of which valences and curtains had been treated with the flame retardant material was not available for review.</p> <p>3.1-19(b)</p>		<p>quarterly by QA committee in quarterly QA meetings.</p>		

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet were enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect 22 residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, the entry door to the oxygen storage and transfilling room had no fire resistance rating label attached to the door. Six four wheeled portable liquefied oxygen containers were observed stored in the oxygen storage and transfilling room. Based on interview at the time of observation, the Maintenance</p>	K010076	<p>K076 It is the intent of this facility to ensure that oxygen storage locations are enclosed with a separation of 1 hour fire resistive construction. 1. Actions Taken: A new fire rated door installed on oxygen storage room. 2. Others Identified: The facility has only one oxygen storage room. 3. Systems in Place: The maintenance director/designee will complete a monthly inspection of all hazardous rooms to meet set standards as a part of the monthly preventative maintenance program. 4. How Monitored: Inspection results will be reviewed by QA committee in quarterly QA meetings.</p>	06/19/2013

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	<p>Director acknowledged the entry door to the oxygen storage and transfilling room was not one hour fire rated.</p> <p>3.1-19(b)</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 liquid oxygen storage areas where transferring of oxygen takes place 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 22 residents and any staff or visitor in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Supervisor during the tour of the facility from 12:20 p.m. to 3:20 p.m. on 05/20/13, the entry door to the</p>	K010143	<p>K143 It is the intent of this facility to ensure that oxygen storage locations are enclosed with a separation of 1 hour fire resistive construction. 1. Actions Taken: A new fire rated door installed on oxygen storage room. 2. Others Identified: The facility has only one oxygen storage room. 3. Systems in Place: The maintenance director/designee will complete a monthly inspection of all hazardous rooms to meet set standards as a part of the monthly preventative maintenance program. 4. How Monitored: Inspection results will be reviewed by QA committee in quarterly QA meetings.</p>	06/19/2013			

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	<p>oxygen storage and transfilling room had no fire resistance rating label attached to the door. Six four wheeled portable liquefied oxygen containers were observed stored in the oxygen storage and transfilling room. Based on interview at the time of observation, the Maintenance Director acknowledged the entry door to the oxygen storage and transfilling room was not one hour fire rated.</p> <p>3.1-19(b)</p>			

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 1 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of</p>	K010144	<p>K144 It is the intent of this facility to ensure that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.</p> <p>1. Actions Taken: Maintenance director/designee completed weekly inspection and monthly load test & emergency 10 second transfer test in accordance with manufacturer's recommendations. Proper documentation maintained and entered into maintenance log. 2. Others Identified: Facility has one emergency generator. 3. Systems in Place: The maintenance director/designee has generator placed on regular service and inspection schedule. 4. How monitored: Maintenance logs will be reviewed by QA committee at quarterly QA meetings.</p>	06/19/2013

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	<p>inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Monthly Load Test Log" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:35 a.m. on 05/20/13, monthly load test documentation for the 04/19/13 stated the emergency generator was load tested for 25 minutes from 1:00 p.m. to 1:25 p.m. The aforementioned load test documentation did not include if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance Director acknowledged documentation for 04/19/13 monthly load test did not indicate the emergency generator ran for a minimum of 30 minutes under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum</p>			

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	<p>exhaust gas temperatures as recommended by the manufacturer.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Monthly Load Test Log" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:35 a.m. on 05/20/13, the following was noted:</p> <p>a) documentation for monthly load tests conducted from 05/09/12 through</p>			

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 05/20/2013
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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>12/31/12 indicated the emergency power transfer time was 12 to 14 seconds.</p> <p>b) emergency power transfer time for monthly load tests conducted from 01/18/13 through 04/19/13 was not documented.</p> <p>Based on interview at the time of record review, the Maintenance Director acknowledged emergency power transfer time was greater than 10 seconds for monthly load tests conducted from 05/09/12 through 12/31/12 and was not recorded for monthly load tests conducted from 01/18/13 through 04/19/13.</p> <p>3.1-19(b)</p>			