

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
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K0000	<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: 12/12/12</p> <p>Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Covington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully</p>	K0000	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.	

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>sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident sleeping rooms are equipped with battery powered smoke detectors. The facility has a capacity of 119 and had a census of 100 at the time of this survey.</p> <p>All areas with resident access were sprinklered except a three sided detached smoke hut. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/17/ 12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>				

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 12 corridor smoke barrier door sets were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 30 or more residents on the skilled and ICF Unit 1 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/12/12 between 11:30 a.m. and 3:30 p.m.:</p> <p>a. One door in the corridor smoke barrier double door set near room</p>	K0021	<p>K-021 It is the intent of this facility to ensure all corridor smoke barrier doors close and latch properly to ensure the safety of all residents, staff and vistiors. A. Corrective Action Taken: All mal-functioning corridor door latches identified will be replaced with properly functioning latches. B. Others Identified: All other cooridor smoke barrier doors have been inspected for this deficiency and found to be compliant according to set standards. C. Measures Taken: The Maintenance Director or designee will monitor each corridor smoke barrier door latching device at the time of each monthly fire drill to ensure proper function and placed on the monthly Preventive Maintenance Program. D. How Monitored: The CEO or designee will review the results of the monthly audits</p>	01/11/2013			

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	<p>42 failed to close when tested twice to ensure its proper operation. The door coordinator on the door frame held the door with the astragal open, the second door closed and the coordinator failed to release the first door leaving an eight inch gap. The maintenance director acknowledged at the time of observations, the coordinator was malfunctioning.</p> <p>b. The smoke barrier doors to ICF Unit 1 didn't close two of five times when tested manually with the maintenance director. The doors failed to close into the door frame again when the fire alarm was activated. The maintenance director said at the time of observations, the doors were "catching " on something in the door frame which needed attention to ensure closure every time.</p> <p>3.1-19(b)</p>		<p>at the quarterly QA Committee Meeting. E. Date Completed: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/11/13.</p>		

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K0025 SS=E	<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 wall and ceiling smoke barriers in 4 of 12 smoke compartments were sealed with an acceptable material to provide the 1/2 hour smoke resistance of the smoke barrier. 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 visitors, staff and 30 or more residents in the center Fountain,</p>	K0025	<p>K-025 It is the intent of this facility to ensure that all smoke barriers are properly sealed with an acceptable material to provide a 30 minute smoke resistant barrier to ensure the safety of the residents, staff and vistiors. A. Corrective Action Taken: a. The expandable foam used to seal the gap in the freezer wall penetration will be removed and replaced with an acceptable material to ensure compliance with set standard. b. -The caulk in the sprinkler riser mechanical room around a ceiling pipe penetration will be replaced and properly sealed -The three penetration in the smoke barrier noted near room #42 will be sealed with proper materials to ensure compiance with the set standard. -The conduit penetration in the Fountain pantry will be sealed with proper materials to ensure compliance with the set standard. B. Others Identified: No other barrier penetration in the facility were</p>	01/11/2013	

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	<p>kitchen and center and north skilled wing smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 12/12/12 at 1:00 p.m., expandable foam was used to seal a gap in the freezer wall heat tape penetration. The maintenance director agreed at the time of observation, the penetration had not been sealed with an acceptable material.</p> <p>b. Based on observation with the maintenance director on 12/12/12 between 11:30 a.m. and 3:30 p.m., unsealed gaps were found:</p> <ul style="list-style-type: none"> -in the sprinkler riser mechanical room where caulk had crumbled around a ceiling pipe penetration leaving a one half inch gap; - the smoke barrier above the corridor ceiling near room 42 had three penetrations which had not been sealed leaving one half to one inch gaps; - A conduit penetration in the Fountain pantry was unsealed leaving a half inch gap. <p>The maintenance director agreed</p>		<p>found to be non-compliant with the set standard. C. Measures Taken: The Maintenance Director or designee will inspect barrier penetrations monthly to ensure compliance with the set standard. These inspections will be a part of the monthly Preventive Maintenance Program. D. How Monitored: The CEO or designee will review the montly audits at the quarterly QA Committee meeting. E: Date Corrected: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/11/13.</p>		

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	<p>at the time of observations, the penetrations had not been properly sealed.</p> <p>3.1-19(b)</p>			

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K0038 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>Based on observation and interview, the facility failed to ensure 1 of 12 exits was arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6.4 requires walking surfaces in the means of egress shall be slip resistant under foreseeable conditions. LSC 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 16 or more residents using the north Fountain exit discharge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/12/12 at 11:30 a.m., the sloped concrete sidewalk discharge from the north Fountain exit had crumbling repair filler for a damaged expansion joint between the concrete sidewalk</p>	K0038	<p>K-038 It is the intent of this facility to ensure all egress exits are free from hazard and safe for all residents, staff and visitors. A. Corrective Action Taken: The crumbling gap in the sloped concrete sidewalk discharging from the north Fountain exit will be repaired with an acceptable filler to ensure compliance with the standard. B. Others Identified: No other egress sidewalks have been identified to require repair. C. Measures Taken: The Maintenance Director or designee will do a visual inspection of all egress sidewalks montly to verify they meet set standards. These inspections will be a part of the monthly Preventive Maintenance Program. D. How Monitored: The CEO or designee will review the results of the monthly audits at the quarterly QA Committee meeting. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/11/13.</p>	01/11/2013			

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	<p>pads. Gaps of one to two inches across the walkway were evident. The maintenance director acknowledged at the time of observation, the damage would continue to erode the condition of the exit discharge surface.</p> <p>3.1-19(b)</p>			

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K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect visitors, staff and 24 or more residents on the skilled wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/12/12 at 12:45 p.m., a sprinkler pipe above the corridor ceiling near room 42 had cables secured to it by a zip tie. The maintenance director agreed at the time of observation, the pipe should not have been used as a hanger to support other equipment installations.</p>	K0062	<p>K-062 It is the intent of this facility to ensure all sprinkler piping are free from external loads and functioning properly. A. Corrective Action Taken: The sprinkler pipe identified above the corridor near room #42 will have the cables attached with a zip tie removed and resecured in another acceptable fashion. B. Others Identified: No other sprinkler pipes were found to have external loads resting or attached to them. C. Measures Taken: The Maintenance Director will monitor and inspect all work performed above the ceiling to ensure that no vendors attach loads to the sprinkler pipe system. D. How Monitored: The Maintenance Director will report any work performed above the ceiling to the quarterly QA Committee Meeting and confirm that the standard is met. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/11.13.</p>	01/11/2013

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	3.1-19(b)			

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K0068 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect 4 or more staff and visitors in the Laundry and adjacent service corridor.</p> <p>Findings include:</p> <p>Based on observation on 12/12/12 at 1:15 p.m. with the maintenance director, the laundry room had two, gas fueled dryers with no fresh air intake. Based on interview at the time of observation, the maintenance director acknowledged the two gas fueled dryers did not have a</p>	K0068	<p>K-068 It is the intent of this facility to ensure that all areas requiring fresh air intake are properly ventelated to meet the standard. A. Corrective Action Taken: The Maintenance Director will install a fresh air intake behind the gas fueled dryers in the ceiling in the laundry room area. B. Others Identified: No other areas in the facility were identified as requiring such ventelation. C. Measures Taken: The Maintenance Director or designee will complete routine audits of the intake fan to ensure proper function and ventelation. The fresh air intake will be audits will be a part of the monthly Preventive Maintenance Program. D. How Monitored: The CEO or designee will review the results of the monthly audit at the quarterly QA Committee meeting. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 01/11/13.</p>	01/11/2013

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	fresh air intake. 3.1-19(b)			

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure flexible cords in 3 of 12 smoke compartments were not used as a substitute for fixed wiring. 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 could affect visitors, staff, and 20 or more residents in the north Fountain, west center and kitchen smoke compartments,</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 12/12/12 between 11:30 a.m. and 3:30 p.m.:</p> <p>a. A power strip extension cord was piggy backed to an extension cord in the beauty shop to supply power to curling iron and blow dryers;</p> <p>b. A power strip was used on the</p>	K0147	<p>K-147 It is the intent of this facility to use power strip extension cords in a safe and acceptable manner A. Corrective Action Taken: The facility has conducted a 100% audit of all rooms to ensure power strip extention are being used in a safe and acceptable manner as determined by set standards. a. The power strip extention cord in the Beauty Shop was removed as a piggy back to an extension cord. b. The power strip was removed from the bedside wall in room #78. c. The power strip was removed from the bedside wall in room #70 d. The heavy guage extension cord used in the freezer will be removed and a hard wired cord will be installed at the proper length. B. Others Identified: No other power strips were found to used in an unacceptable manner as determined by set standards. C. Measures Taken: The Maintenance Director and Housekeeping Supervisor will audit rooms throughout the facility monthly to determine the proper use of power strip extension cords. This audit will be added to the monthly Preventive Maintenance Program. D. How Monitored: The CEO or designee will review the results of the</p>	01/11/2013	

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	<p>bedside wall in room 78 for an electric chair charger;</p> <p>c. A power strip was used on the bedside wall in room 70 for an electric lift chair and other equipment;</p> <p>d. A heavy gauge extension cord powered the heat tape around conduit in the freezer.</p> <p>The maintenance director said at the time of observations, the extension cord in the freezer was needed because the heat tape cord was too short and he had been unaware of restrictions for the used of power strips and extension cords.</p> <p>3.1-19(b)</p>		<p>monthly audit at the quarterly QA Committee meeting. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 01/11/13.</p>				