

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 06/27/2014
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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: 06/27/14</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</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 c 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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K010029 SS=D	<p>sleeping rooms. The facility has a capacity of 103 and had a census of 93 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered except for one detached smoking shed. The facility has one detached storage shed providing facility storage services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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>			
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	<p>Based on observation and interview, the facility failed to ensure 1 of 7 hazardous areas such as laundries greater than 100 square feet were separated from other areas by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 5 staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 06/27/14, the Dietary entrance door from the Laundry was propped in the fully open position with an affixed door stop. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hazardous area was not separated from other spaces by a self closing door.</p> <p>3.1-19(b)</p>	K010029	<p>K029 It is the intent of this facility to ensure hazardous areas such as laundries greater than 100 square feet are separated from other areas by self-closing doors. Doors to hazardous areas are self-closing or close automatically upon activation of the fire alarm system.</p> <p>1. Action Taken: Door stop removed, door inspected/tested to meet standards. 2. Others Identified: All hazardous areas were inspected/tested to meet set standards. 3. Systems in Place: The maintenance supervisor/designee will inspect all hazardous areas as part of preventative maintenance program. 4. How Monitored: Inspection reports will be reviewed by the QA committee during quarterly QA meetings.</p>	07/27/2014

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K010038 SS=D	<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 over 75 doors did not require more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect 5 staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 06/27/14, the Dietary entrance door from the Laundry has two locks, one on the</p>	K010038	<p>K038 It is the intent of this facility to ensure that doors do not require more than one releasing operation.</p> <p>1. Actions Taken: Deadbolt removed from dietary door. 2. Others Identified: All doors inspected inspected/tested to meet standards. 3. Systems in Place: Maintenance director/designee will inspect all doors as part of the preventative maintenance program. 4. How Monitored: Inspection reports will be reviewed by QA committee during quarterly QA meetings.</p>	07/27/2014

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K010050 SS=F	<p>door handle and a deadbolt for which a key was needed to unlock the door on the Laundry room side of the door. Based on interview at the time of observation, the Maintenance Director acknowledged the Dietary entrance door from the Laundry required more than one releasing operation to open the door.</p> <p>3-1.19(b)</p> <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>1. 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 affects all residents, staff and visitors.</p>	K010050	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 and conducted fire drills on all three shifts @ unexpected times, under varying	07/27/2014

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	<p>Findings include:</p> <p>Based on review of "Fire Drill Report" with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 06/27/14, documentation of a fire drill conducted on the first shift in the first quarter of 2014 was not available for review. Based on interview at the time of record review, the Maintenance Director stated no other fire drill documentation was available for review and acknowledged documentation of a fire drill conducted on the first shift in the first quarter of 2014 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 06/27/14, third shift fire drills conducted on 09/15/13, 12/17/13 and</p>		<p>conditions. 2. Others identified: No others identified. 3. Systems in Place: Maintenance director/designee will conduct fire drills at least quarterly on each shift @ unexpected times under varying conditions and provide proper documentation. 4. How Monitored: Fire drill logs will be reviewed by QA committee at quarterly QA meeting.</p>	

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K010067 SS=F	<p>06/24/14 were conducted at, respectively, 4:55 a.m., 5:20 a.m. and 5:10 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged third shift fire drills were not conducted at unexpected times under varying conditions.</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 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</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.</p> <p>1. Action Taken: Submitted Safety Code Waiver Request. 2. Others Identified: Waiver encompasses entire facility. See attachments.</p>	07/27/2014			

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K010130 SS=C	<p>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 during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 06/27/14, 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>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke</p>	K010130	K130 It is the intent of this facility to ensure that the facility maintain a preventative maintenance program for battery operated smoke detectors. 1. Action	07/27/2014			

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	<p>detectors installed in 51 of 51 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 either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2013 and 2014" with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 06/27/14, documentation of battery operated smoke detector cleaning within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 06/27/14, Firex Model C battery operated smoke detectors are installed in each of 51 resident sleeping rooms. Manufacturer's specifications affixed to the smoke detectors did not state the required frequency of cleaning, however, an Internet review of the manufacturer's specifications stated to "clean and vacuum the openings of the smoke alarm once a month." Based on interview at the time of record review and of the observations, the Maintenance Director acknowledged documentation of monthly</p>		<p>Taken: All battery operated smoke detectors cleaned according to manufacturer's guidelines. 2. Others identified: No others identified. 3. Systems in Place: Maintenance director/designee will clean smoke detectors on a monthly basis and provide proper documentation. 4. How Monitored: Preventative maintenance logs will be reviewed by QA committee at quarterly QA meetings. K130 (con't) It is the intent of this facility to ensure that fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. 1. Action Taken: All 6 waters heaters were inspected and current certificates affixed to each. 2. Others identified: No others identified. 3. Systems in Place: Maintenance director/designee will request inspections on annual basis and provide proper documentation. 4. How Monitored: Preventative maintenance log will include annual inspection date and will be reviewed by QA committee at quarterly QA meeting to ensure inspections are completed on annual basis.</p>	

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	<p>battery operated smoke detector cleaning was not available for review.</p> <p>3.1-19(a)</p> <p>2. Based on observation and interview, the facility failed to ensure 6 of 6 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 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 occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 06/27/14, each of six fuel fired water heaters in the facility had expired Certificate of Inspection documentation from the State of Indiana as of 04/09/14. Based on interview at the time of the observations, the Maintenance Director stated current Certificate of Inspection documentation was not available for review and acknowledged the aforementioned service water heaters had expired Certificate of Inspection documentation from the State of Indiana.</p>			

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K010144 SS=C	<p>3.1-19(b)</p> <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>Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 3 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</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: Emergency Generator was inspected and serviced by licensed contractor in accordance with manufacturer's recommendations, including load test & emergency 10 second transfer test. Proper documentation maintained and entered into maintenance log. 2. Others Identified: Facility has one emergency generator. 3. Systems in Place: The maintenance director/designee will conduct monthly load testing and provide documentation which includes operating and exhaust gas temperatures. In addition licensed</p>	07/27/2014

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	<p>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 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 Test Log" documentation with the Maintenance Director during record review from 9:30 a.m. to 12:10 p.m. on 06/27/14, documentation of monthly load testing on 04/04/14, 05/02/14 and 06/02/14 each recorded the monthly load test as less than 30% of the Emergency Power Supply (EPS) nameplate rating. In addition, each of the aforementioned monthly load tests did not document the test was under operating temperature conditions or at loading which maintains</p>		<p>contractor will conduct service and inspection on an annual basis. 4.</p> <p>How monitored: Maintenance logs will be reviewed by QA committee at quarterly QA meetings.</p>				

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K010147 SS=E	<p>the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of the aforementioned monthly load tests were not conducted under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute</p>	K010147	K147 It is the intent of this facility to ensure electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2. 1. Actions Taken: Power strip was removed from therapy office and appliances were properly plugged in to proper outlet.2. Others	07/27/2014

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	<p>for fixed wiring of a structure. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Therapy Office by the Serenity Cove Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:50 p.m. to 3:00 p.m. on 06/27/14, a microwave oven and a refrigerator were plugged into a power strip which was plugged into an extension cord in the Therapy Office by the Serenity Cove Hall. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip and an extension cord were being used as a substitute for fixed wiring in the Therapy Office by the Serenity Cove Hall.</p> <p>3.1-19(b)</p>		<p>identified: Maintenance director/designee conducted facility inspection to ensure no other power strips were in use. 3. Maintenance Director/Designee will conduct daily rounds to ensure power strips are not in use. 4. How Monitored: Preventative Maintenance logs will be reviewed by QA committee at quarterly QA meeting.</p>	