

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155238	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF YORKTOWN THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S ANDREWS RD YORKTOWN, IN 47396
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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: 03/12/14</p> <p>Facility Number: 000143 Provider Number: 155238 AIM Number: 100283890</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Yorktown 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in resident sleeping rooms. The facility has</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>a capacity of 100 and had a census of 68 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 except the four detached sheds for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/18/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 sets of double leaf corridor doors could latch independently into their door frame. This deficient practice could affect 1 resident observed in the Dining room and 3 residents observed in the adjacent Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/12/14 at 2:00 p.m. with the Maintenance Supervisor, the set of double leaf corridor doors leading into the Kitchen adjacent to the Main dining room required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly</p>	K010018	<p><b>K018</b></p> <p>1) 1) The four residents identified that this deficient practice could affect have been addressed by the following implementation: The set of double leaf corridor doors identified have been adjusted and now latch independently.</p> <p>2) 2) It was determined that all residents of this facility have the potential to be affected by this deficient practice. To prevent this the double leaf doors have now been adjusted and now latch independently.</p> <p>3) 3) The maintenance man will inspect these doors weekly X 6 weeks to ensure proper operation and then monthly X 8 weeks.</p> <p>4) 4) The Administrator and/or her designee will monitor the inspection reports provided by the maintenance supervisor monthly</p>	03/14/2014
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	<p>into the door frame. Based on interview on 03/12/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the aforementioned set of corridor doors would not latch independently into the door frame.</p> <p>3.1-19(b)</p>		<p>X12 weeks. Results of Administrator's review will be delivered to the QA&amp;A committee for their review.</p> <p>5) Completion date March 14, 2014</p>	

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K010029 SS=E	<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> <p>Based on observation and interview, the facility failed to ensure 1 of 1 doors leading to hazardous areas on 400 hall such as rooms with combustibile items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 26 residents on 400 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/12/14 at 12:55 p.m. with the Maintenance Supervisor, the Storage room on 400 hall contained forty two cardboard boxes inside the room which was greater than fifty square feet in size, did not have a self closing device on the corridor door. Based on interview on 03/12/14 at 12:58 p.m. with the Maintenance Supervisor, it</p>	K010029	<p><b>K029</b> 1) 1) The appropriate self-closing device has been added to the storage room door correcting the deficient practice which potentially affected 26 residents. Door now functions per requirement. 2) 2) Upon review, no other residents were found to be potentially affected by this deficient practice. 3) 3) The maintenance man will inspect this door weekly X 6 weeks to ensure proper operation and then monthly X 8 weeks. 4) 4) The Administrator and/or her designee will monitor the inspection reports provided by the maintenance supervisor monthly X12 weeks. Results of Administrator's review will be delivered to the QA&amp;A committee for their review. 5) 5) Completion date March 14, 2014</p>	03/14/2014			

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	<p>was acknowledged the aforementioned door leading into the Storage room containing combustible items was not equipped with a self closing device on the door.</p> <p>3.1-19(b)</p>			
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K010068 SS=E	<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 Based on observation and interview, the facility failed to ensure 2 of 2 gas dryers in the laundry room on 100 hall were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 24 residents on 100 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/12/14 at 2:07 p.m. with the Maintenance Supervisor, the two gas fueled dryers in the laundry room had a fresh air intake, but it was closed off with duct tape. Based on interview on 03/12/14 at 2:09 p.m., it was acknowledged by the Maintenance Supervisor since the fresh air intake was sealed off with duct tape it could not serve as a fresh air intake for the gas dryers.</p> <p>3.1-19(b)</p>	K010068	<p><b>K068</b> 1) The deficient practice potentially affecting 24 residents on the 100 hall has been corrected by removal of blockage from the fresh air intake vent within the laundry room. 2) Upon review, no other residents were found to be potentially affected by this deficient practice. 3) The maintenance supervisor will inspect fresh air intake vent in laundry room weekly X 6 weeks and then monthly X 8 weeks. 4) The Administrator and/or her designee will monitor the inspection reports provided by the maintenance supervisor monthly X 12 weeks. Results of Administrator's review will be delivered to the QA&amp;A committee for their review. 5) Completion date March 14, 2014</p>	03/14/2014			

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K010147 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 1 of 1 multiplug adapters was not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires unless specifically permitted, multiplug adapters, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 24 residents on 200 hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 03/12/14 at 1:33 p.m. with the Maintenance Supervisor, there was one, three prong multiplug adapter connected to a wall outlet which was used to power a computer in the MDS office. Based on interview on 03/12/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged it is the policy of the facility not to use multiplug adapters, however, the aforementioned room did use a three prong multiplug as a substitute for fixed wiring.</p> <p>3.1-19(b)</p>	K010147	<p><b>K147</b></p> <p>1) The deficient practice potentially affecting 24 residents on the 200 hall has been corrected by removal of the multiplug adapter.</p> <p>2) In order to ensure no other residents were affected, the maintenance supervisor inspected all power outlets and found no other multiplug adapters in use. No other residents were affected by this deficient practice.</p> <p>3) The maintenance man will inspect all power outlets throughout facility X 6 weeks and then monthly X 8 weeks.</p> <p>4) The Administrator and/or her designee will monitor the inspection reports provided by the maintenance supervisor monthly X 12 weeks. Results of Administrator's review will be delivered to the QA&amp;A committee for their review.</p> <p>5) Completion date March 14, 2014</p>	03/14/2014			

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