

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155409	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227
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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: 09/26/12</p> <p>Facility Number: 000537 Provider Number: 155409 AIM Number: 100267270</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Waters of Indianapolis 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 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 detectors in all resident sleeping</p>	K0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or</p> <p>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 81 and had a census of 65 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing storage which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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>1. Based on observation and interview, the facility failed to ensure 1 of 5 exit accesses was provided with a handrail. LSC 7.2.2.4.2 states ramps shall have handrails on both sides. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice could affect 24 residents, staff and visitors using the Faith Hallway exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:20 a.m. to 12:35 p.m. on 09/26/12, the slope in the direction of travel of the walking surface outside the building at the Faith Hallway exit access ramp measured 1 in 13.6 and the exit access ramp was not provided with a handrail. The Faith Hallway exit ramp measured three hundred inches long and the ramp height at the exit door was twenty two inches higher than at the discharge to the public way as determined</p>	K0038	<p>K038</p> <p>I. The concrete ramp on the Hope Hall exit is scheduled to be replaced by a licensed contractor along with the addition of a handrail on the Faith Hall exit ramp on October 19, 2012.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Director of Maintenance or his designee will observe all facility exits for hazards five times weekly and report all problems to the administrator for appropriate action.</p>	10/26/2012			

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	<p>with a measuring tape. Based on interview at the time of observation, the Maintenance Director acknowledged the Faith Hallway outside exit ramp slope measured 1 in 13.6 and was not provided with a handrail.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a level walking surface was provided for 1 of 5 exits. LSC 7.1.6.3 states walking surfaces in the means of egress shall be nominally level. This deficient practice could affect 24 residents, staff and visitors using the Hope Hallway exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:20 a.m. to 12:35 p.m. on 09/26/12, a thirty foot length of the outside walking surface next to the building in the means of egress at the Hope Hallway exit measured five inches higher from the building side to the lawn side as determined by using a measuring tape. Based on interview at the time of observation, the Maintenance Director acknowledged a thirty foot length of the walking surface next to the building outside the Hope Hallway exit measured</p>		<p>IV.</p> <p>The results of these observations will be reported to the Quality Assurance Committee monthly to ensure continued compliance.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is:</p> <p>October 26, 2012</p>				

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	<p>measured five inches higher at the building side of the surface than at the lawn side of the surface.</p> <p>3.1-19(b)</p>			

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K0048 SS=B	<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 and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans 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 affects staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of "Disaster Plan for Waters of Indianapolis, LLC: Fire Plan" documentation with the Maintenance Director during record review from 9:10 a.m. to 10:20 a.m. on 09/26/12, the facility's written fire safety plan did not address the use of ABC type fire extinguishers and the K-class fire</p>	K0048	<p>K048</p> <p>I. The facility Disaster Plan has been updated to include the use of the K – class fire extinguishers in the kitchen.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p> <p>III. The Disaster Plan will be reviewed annually and updated as required.</p> <p>The Administrator will hold a staff education session on the updated Disaster Plan on October 17, 2012. The information will also be included in annual fire safety</p>	10/26/2012			

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>education sessions and with all new hire orientations.</p> <p>IV.</p> <p>The Director of Maintenance or his designee will audit disaster/fire safety education and training events monthly and report findings to the Quality Assurance Committee.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is:</p> <p>October 26, 2012</p>	

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K0076 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 was enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect 24 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 during a tour of the facility from 10:20 a.m. to 12:35 p.m. on 09/26/12, the entry door to the oxygen storage and transfilling room had a twenty minute fire resistance rating label attached to the door. Nine liquid oxygen tanks were observed in the room. Based on interview at the time of observation, the Maintenance Director acknowledged the entry room door to the oxygen storage and transfilling room did not provide one hour</p>	K0076	<p>K076</p> <p>I. The door for the oxygen storage and transfilling room has been replaced. The door now meets the one hour fire resistive construction requirements.</p> <p>II. All residents, visitors and staff have the potential to be effected by this practice.</p>	10/26/2012	

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	fire resistive construction. 3.1-19(b)		<p>III.</p> <p>No other rooms are used for the storage or transferring of oxygen. The oxygen door was added to the preventative maintenance monthly rounds.</p> <p>IV.</p> <p>The Director of Maintenance or his Designee will audit monthly rounds and report findings in the monthly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is:</p> <p>October 26, 2012</p>		

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K0143 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 transfer areas was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 24 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 during a tour of the facility from 10:20 a.m. to 12:35 p.m. on 09/26/12, the entry door to the oxygen storage and transfilling room had a twenty minute fire resistance rating label attached</p>	K0143	<p>K143</p> <p>I.</p> <p>The door for the oxygen storage and transfilling room has been replaced. The door now meets the one hour fire resistive construction requirements.</p> <p>II.</p> <p>All residents, visitors and staff have the potential to be</p>	10/26/2012			

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	<p>to the door. Nine liquid oxygen tanks were observed in the room. Based on interview at the time of observation, the Maintenance Director stated oxygen transfilling does occur in the room and acknowledged the oxygen storage and transfilling room door did not provide one hour fire resistive construction.</p> <p>3.1-19(b)</p>		<p>effected by this practice.</p> <p>III.</p> <p>No other rooms are used for the storage or transferring of oxygen. The oxygen door was added to the preventative maintenance monthly rounds.</p> <p>IV.</p> <p>The Director of Maintenance or his Designee will audit monthly rounds and report findings in the monthly Quality Assurance meeting.</p> <p>V.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is:</p> <p>October 26, 2012</p>	