| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155183 | A. BUILDING -- B. WING | 10/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| WATERS OF MARTINSVILLE, THE | 2055 HERITAGE DR MARTINSVILLE, IN 46151 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 10/20/22<br><br>Facility Number: 000096<br>Provider Number: 155183<br>AIM Number: 100290890<br><br>At this Emergency Preparedness survey, The Waters of Martinsville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 103 certified beds. At the time of the survey, the census was 66.<br><br>Quality Review completed on 10/21/22 | E 0000 | Plan of Correction Text:<br>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of 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. Facility's date of alleged compliance is: October 21, 2022. Facility is respectfully requesting paper compliance for all deficiencies in this POC. | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 10/20/22<br><br>Facility Number: 000096<br>Provider Number: 155183<br>AIM Number: 100290890<br><br>At this Life Safety Code survey, The Waters of Martinsville was found not in compliance with | K 0000 | Plan of Correction Text:<br>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of 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 |
|---|---|---|
| Keith McKee | | 11/04/2022 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>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 rooms. The facility has a capacity of 103 and had a census of 66 at the time of this visit.<br><br>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.<br><br>Quality Review completed on 10/21/22 | | Facility's date of alleged compliance is: October 21, 2022. Facility is respectfully requesting paper compliance for all deficiencies in this POC. | |
| K 0321 SS=D Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that | | | |

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| | do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322) | | | |
| | Based on observation and interview, the facility failed to ensure 1 of over 4 hazardous areas such as combustible storage rooms greater than 50 square feet in size were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 5 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations with the Maintenance Director during a tour of the facility from at 12:40 p.m. to 1:20 p.m. on 10/20/22, resident sleeping room 15, across the corridor from therapy, was unoccupied and was being used as a storage room for combustible boxes and supplies. The room was greater than 50 square feet in size. The corridor door to the room was not equipped with a self closing device. Based on interview at the time | K 0321 | **K321**– It is the intent of the facility to ensure hazardous areas such as combustible storage rooms greater than 50 square feet in size are separated from other spaces by smoke resistant partitions and doors to meet set standards.<br>1. **CORRECTIVE ACTIONS TAKEN**:<br>a. On 10.26.22, the Maintenance Supervisor/designee installed a self-closing device to the corridor door to resident sleeping room 15, across the corridor from therapy that is being used as a storage room for combustible boxes and supplies to meet set standards. The Administrator verified the work on 10.26.22. | 11/03/2022 |

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| | of the observation, the Maintenance Director agreed the corridor door to Room 15 was not equipped with a self closing device.<br><br>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:<br>a. All residents and all staff and visitors have the potential to be affected but none were. On 10.26.22, the Maintenance Supervisor/designee inspected all hazardous areas for self-closing devices and found no other negative findings.<br>**3. MEASURES TO PREVENT REOCCURRENCE**:<br>a. On 11.3.22, the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that all hazardous area doors must have self-closing devices to meet set standards.<br>b. Maintenance Supervisor/designee will inspect all hazardous area doors throughout the facility monthly for functioning self-closing devices as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br>c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br>**4. MONITORING** | |

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| | | | **CORRECTIVE ACTION**:<br>a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.<br>**This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11.3.22.** | |
| K 0324<br>SS=D<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments | | | |

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| | with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br>Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression system was completely maintained. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition at 10.2.6 requires automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (4) NFPA 17A. NFPA 17A, Wet Chemical Extinguishing Systems Inspection, Maintenance, and Recharging, requires wet chemical containers shall be subject to a hydrostatic pressure test at intervals not exceeding 12 years. This deficient practice was not in a resident area but could affect kitchen staff.<br><br>Findings include:<br><br>Based on record review on 10/20/22 at 11:17 a.m. with the Maintenance Director present, the 07/08/22 fire suppression system inspection report for the range hood noted in Remarks/Comments section "Tank is due for a hydrotest". Based on interview at the time of record review, the Maintenance Director confirmed the inspection report indicated the tank is due for a hydrotest and there was no documentation to review at the time of the survey to show that the 12 year maintenance has taken place. | K 0324 | **K324**– It is the intent of the facility to ensure the kitchen fire suppression system is completely maintained to meet set standards.<br>**1. CORRECTIVE ACTIONS TAKEN**:<br>a. On 11.9.22, a Certified Contractor is scheduled to perform the hydrotest on the tank and document the results in the Life Safety Survey to meet set standards. The Administrator will verify the work on 11.9.22.<br>**2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:<br>a. All residents and all staff and visitors have the potential to be affected but none were.<br>**3. MEASURES TO PREVENT REOCCURRENCE**:<br>a. On 11.2.22, the Administrator in-serviced the Maintenance Supervisor/designee on the requirement that the kitchen fire suppression system must be maintained and hydrotest completed every 12 years to meet set standards.<br>b. Maintenance Supervisor/designee will inspect the kitchen fire suppression system to ensure it is maintained | 11/09/2022 |

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| | This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | and the hydrotest is completed every 12 years as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br>c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br>**4. MONITORING CORRECTIVE ACTION**:<br>a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.<br>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11.9.22. The current hydro test does not expire | |

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| | | | until 12.31.22. | |
| K 0363<br>SS=D<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. | | | |

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| | 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>Based on observation and interview, the facility failed to ensure 1 of over 30 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director on 10/20/22 during a tour of the facility between 12:40 p.m. and 1:20 p.m., the corridor door to resident room 16, which was unoccupied, did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the corridor door would not latch into the door frame, and would work on the door so it would latch.<br><br>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | K 0363 | **K363** – It is the intent of the facility to ensure corridor doors are provided with a means suitable for keeping the door closed, no impediments to closing, latching and will resist the passage of smoke to meet set standards.<br>**1. CORRECTIVE ACTIONS TAKEN**:<br>a. On 10.28.22, the Maintenance Supervisor/designee repaired the latching mechanisms on the corridor door to resident room 16 to ensure it latches fully into the frame to meet set standards. The Administrator verified the work on 10.28.22.<br>**2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:<br>a. All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors for failing latching mechanisms and found no other negative findings.<br>**3. MEASURES TO PREVENT REOCCURRENCE**:<br>a. On 11.2.22, the Administrator in-serviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors latching mechanism latches fully into the | 11/02/2022 |

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| | | | frame to meet set standards.<br>b. Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure the latching mechanisms work properly and latch fully into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br>c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br>**4. MONITORING CORRECTIVE ACTION**:<br>a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. | |

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| | | | **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11.2.22.** | |
| K 0761 SS=E Bldg. 01 | Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen transfilling room fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, | K 0761 | **K761** – It is the intent of the facility to ensure to annual inspection and testing of oxygen transfilling room fire door assemblies are completed in accordance with LSC 19.1.1.4.1.1 to meet set standards.<br>1. **CORRECTIVE ACTIONS TAKEN**:<br>a. On 10.29.22, the Maintenance Supervisor/designee conducted the annual testing and inspections of required fire rated doors including the oxygen transfilling/storage room and documented those inspection results on the Annual Door Inspections log to meet set standards. The Administrator verified the inspections and documentation on 10.29. 22..<br>2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:<br>a. All residents and all staff and visitors have the potential to be affected but none were.<br>3. **MEASURES TO PREVENT REOCCURRENCE**:<br>a. On 11.2.22, the Administrator in-serviced the | 11/02/2022 |

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| | the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect at least 10 residents and staff in the vicinity of the oxygen room.<br><br>Findings include:<br><br>Based on record review with the Maintenance Director on 10/20/22 at 12:38 p.m., no annual inspection of the oxygen transfilling/storage room fire door assembly was available for review. Based on observation during the tour between 12:40 p.m. and 1:20 p.m., the oxygen room, located across the corridor from Comfort Creek bath, has a 1 hour fire | | Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire rated doors must be conducted and documented on the Annual Door Inspections log and maintained at the facility to meet set standards.<br>b. Maintenance Supervisor/designee will conduct the annual door inspections and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results.<br>c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.<br>4. **MONITORING CORRECTIVE ACTION**:<br>a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155183 | A. BUILDING 01<br>B. WING | 10/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WATERS OF MARTINSVILLE, THE | 2055 HERITAGE DR<br>MARTINSVILLE, IN 46151 |

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|---|---|---|---|---|
| | door assembly. Based on interview at the time of records review, the Maintenance Director stated an annual inspection was not conducted for the oxygen room fire door assembly in the last year and wasn't aware it needed to be inspected. The Maintenance Directed stated he would add the oxygen room fire door the the annual inspection.<br><br>This finding was reviewed with the Administrator and Maintenance Director at the exit conference.<br><br>3.1-19(b) | | subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11.2.22.** | |