An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.

Survey Date: 04/10/18

Facility Number: 000537
Provider Number: 155409
AIM Number: 100267270

At this Emergency Preparedness survey, The Waters of Indianapolis was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.

The facility has 81 certified beds. At the time of the survey, the census was 47.

Quality Review completed on 04/13/18 - DA

The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:

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. The facility respectfully requests paper compliance for these citations.

Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73.

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. The facility respectfully requests paper compliance for these citations.
<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Identification Number</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>X1) Provider/Supplier/CLIA</td>
<td>155409</td>
<td>04/10/2018</td>
</tr>
<tr>
<td>X2) Multiple Construction</td>
<td></td>
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<tr>
<td>A. Building</td>
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<tr>
<td>B. Wing</td>
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</table>

**Name of Provider or Supplier:**
Waters of Indianapolis, The
3895 S Keystone Ave
Indianapolis, IN 46227

**ID**
E 0026
SS=C
Bldg. --

**Summary Statement of Deficiency**
483.73(b)(6). This deficient practice could affect all occupants.

Findings include:

Based on review of "Emergency Operations Plan" with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, the emergency preparedness plan for the facility did not include the use of volunteers in an emergency or other emergency staffing strategies. Based on interview at the time of record review, the Administrator agreed the aforementioned policy did not address the use of volunteers in an emergency or other emergency staffing strategies.

**Provider's Plan of Correction**

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<th>ID</th>
<th>Prefix</th>
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<th>Completion Date</th>
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<tr>
<td>E 0026</td>
<td>E 026</td>
<td>05/10/2018</td>
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1. **What we did** - The facility has added a policy and procedure that expressly states the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8).

2. **Who could be affected** - All residents have the potential to be affected by this deficient practice.

3. **How we are monitoring** - All staff will be inserviced on May 9th 2018 on the changes made to the Emergency Operations Plan which includes information related to the use of volunteers or other emergency staffing strategies. The facility will review the Emergency Operations Plan to identify any other sections that have not been included. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Administrator 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.

4. **Date of compliance** - May 10th
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**IDENTIFICATION NUMBER**

<table>
<thead>
<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
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<tr>
<td>155409</td>
<td>A. BUILDING --</td>
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<td>B. WING</td>
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**DATE SURVEY COMPLETED**

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<th>X3) DATE SURVEY</th>
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<tr>
<td>04/10/2018</td>
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</table>

**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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**SUMMARY STATEMENT OF DEFICIENCY**

**PREFIX**

**TAG**

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<tr>
<th>ID</th>
<th>REGULATORY OR LSC IDENTIFYING INFORMATION</th>
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**PROVIDER'S PLAN OF CORRECTION**

**PREFIX**

**TAG**

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<th>CROSS-REFERENCED TO THE APPROPRIATE</th>
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<td>DEFICIENCY</td>
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Based on review of "Emergency Operations Plan" with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, the emergency preparedness plan for the facility did not expressly state the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview at the time of record review, the Administrator stated the role of the facility under section 1135 is addressed in emergency preparedness documentation but could not locate the documentation for the facility under a waiver declared by the Secretary at the time of the survey.

**E 0030 SS=C Bldg. --**

1. **What we did** - The facility added to the emergency preparedness plan a plan that includes identifying volunteers who may be used or who are at the facility in an emergency.

**E 0030**

**05/10/2018**

2. **Who could be affected?** - All residents have the potential to be affected by this deficient practice.

3. **How we are monitoring** - All staff will be inserviced on May 9th 2018 on the changes made to the Emergency Operations Plan which includes information related to the Section 1135. The facility will review the Emergency Operations Plan to identify any other sections that have not been included. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Administrator 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.

4. **Date of compliance** - May 10th 2018

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**Findings include:**

Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Patients' physicians (iv) Volunteers in accordance with 42 CFR 416.54(c)(1). This deficient practice could affect all occupants.

**E 030**

**05/10/2018**

1. **What we did** - The facility added to the emergency preparedness plan a plan that includes identifying volunteers who may be used or who are at the facility in an emergency.

2. **Who could be affected?** - All residents have the potential to be affected by this deficient practice.
Based on review of "Emergency Operations Plan" with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, the emergency preparedness plan communication plan was incomplete. The emergency preparedness plan did not include identifying volunteers who may be used or who are at the facility in an emergency. Based on interview at the time of record review, the Administrator stated the did not identify volunteers in the facility.

1. What we did - The facility will conduct a community based disaster drill of a natural or man-made emergency that requires activation of the emergency plan.
2. Who could be affected - All residents have the potential to be affected by this deficient practice.
3. How we are monitoring - All staff will be inserviced on May 9th 2018 on the changes made to the Emergency Operations Plan which includes information on identifying volunteers who may be used in an event of an emergency. The facility will review the Emergency Operations Plan to identify any other sections that have not been included. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Administrator 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.
4. Date of Compliance - May 10th 2018
<table>
<thead>
<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
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<th>X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>155409</td>
<td>A. BUILDING</td>
<td>04/10/2018</td>
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<td>B. WING</td>
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**WATERS OF INDIANAPOLIS, THE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3895 S KEYSTONE AVE
INDIANAPOLIS, IN 46227

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 0000</td>
<td>Full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.</td>
<td></td>
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Findings include:

Based on review of "Emergency Operations Plan" with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, documentation for testing the facility's emergency preparedness program twice within the most recent twelve month period was not available for review. One tabletop exercise with the Beech Grove Fire Department was documented on 12/05/17. Based on interview at the time of record review, the Administrator stated the facility has not conducted a community based disaster drill or experienced and documented a natural or man-made emergency that requires activation of the emergency plan within the most recent twelve month period.

**K 0000 Bldg. 01**

A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana

**Preparation and/or execution of this plan of correction in**

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 rooms. The facility has a capacity of 81 and had a census of 47 at the time of this visit.

All areas where residents have customary access were sprinklered. The facility has one detached building providing storage and a detached smoking shed which were each not sprinklered.

Quality Review completed on 04/13/18 - DA

**NFPA 101**

**Egress Doors**

Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the 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. The facility respectfully requests paper compliance for these citations.
egress side unless using one of the following special locking arrangements:

**CLINICAL NEEDS OR SECURITY THREAT LOCKING**

Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.

18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6

**SPECIAL NEEDS LOCKING ARRANGEMENTS**

Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.

18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4

**DELAYED-EGRESS LOCKING ARRANGEMENTS**

Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire...
Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors if using the exit door from the Therapy Room to the outside of the facility.

Findings include:

Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, the door to the outside of the facility in the Therapy Room was marked as a facility exit, the detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4

ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS

Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4

ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS

Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4

1. What we did - The Maintenance Director posted the passcode near the exit door in the Therapy room marked as an exit.

2. Who could be affected - All residents have the potential to be affected by this deficient practice.

3. How we are monitoring - The Maintenance Director received 1:1 inservice training on 4/25/14 related to this deficient practice. An audit of any other comparable issues related to this deficient practice will be conducted through a facility. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed

05/10/2018
WATERS OF INDIANAPOLIS, THE  

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  

NAME OF PROVIDER OR SUPPLIER  

STREET ADDRESS, CITY, STATE, ZIP CODE  

SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  

ID  
PREFIX  
TAG  

TERMINATED BY:  

1. Exit door could be opened by entering a four digit code in a keypad, but the exit code was not posted at the exit door. Based on interview at the time of the observations, the Maintenance Supervisor agreed the code was not posted at the Therapy Room exit.

3.1.19(b)

NFPA 101 
Emergency Lighting 
Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9, 18.2.9.1, 19.2.9.1

Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors.

Findings include:

Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, one battery powered lighting system was located in the generator room inside the Maintenance Office which did not function when its respective test button was pushed five separate times. Based on interview at the time of the observations, the Maintenance Supervisor agreed

by the Maintenance Director 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.

4. Date of compliance - May 10th 2018

1. What we did - The Maintenance Director replaced the batteries in the battery powered emergency lighting located in the Generator Room in the facility.

2. Who could be affected - All residents have the potential to be affected by this deficient practice.

3. How we are monitoring - The Maintenance Director received 1:1 inservice training on 4/25/14 related to this deficient practice. An audit of any other comparable issues related to this deficient practice will be conducted throughout the facility. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Maintenance Director 1 time per week for 3 months or until
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<th>SUMMARY STATEMENT OF DEFICIENCY</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>DATE</th>
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<tbody>
<tr>
<td>K 0293</td>
<td>SS=D</td>
<td>Bldg. 01</td>
<td>the lighting system failed to illuminate when its respective test button was pushed multiple times.</td>
<td>3.1-19(b)</td>
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<td></td>
<td>NFPA 101 Exit Signage</td>
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<td>Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to install exit signage for 1 of 7 facility exits in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect over three staff and visitors if needing to exit the facility from the Breakroom. Findings include: Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, the exit door to the outside of the facility in the Breakroom is not marked as a facility exit with an</td>
<td>K 0293</td>
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<td>the issue is remedied and approved by the QA team to ensure ongoing compliance. 4. Date of Compliance - May 10th 2018</td>
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</table>

1. What we did - The Maintenance Director installed an exit sign above the door to the outside located in the break room.
2. Who could be affected - All residents have the potential to be affected by this deficient practice.
3. How we are monitoring - The Maintenance Director received 1:1 inservice training on 4/25/14 related to this deficient practice. An audit of any other comparable issues related to this deficient practice will be conducted throughout the facility. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Maintenance Director 1.
exit sign. The exit door was also not marked by a 'NO EXIT' sign. Based on interview at the time of the observations, the Administrator and the Maintenance Supervisor stated staff use the exit door to the outside of the facility and agreed the path of egress to the public way from the Breakroom was not marked with exit or directional signage.

NFPA 101 Protection - Other Protection - Other
List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.

Based on record review, observation and interview; the facility failed to ensure preventative maintenance for all battery operated smoke alarms in resident rooms was performed. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect over all residents, staff, and visitors.

Findings include:

Based on review of "Smoke Detector Log" documentation with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, weekly battery operated smoke detector testing documentation for March 2018 was not available for review. In addition, monthly battery operated smoke detector cleaning documentation for the

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<th>ID</th>
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<tbody>
<tr>
<td>K 0300</td>
<td>1. What we did - The Maintenance Director will complete all battery powered smoke detector testing and cleaning on a weekly basis and will document these tests and cleanings. The Facility will create a new preventative document and add cleaning to the weekly schedule for battery powered smoke detectors in all resident rooms. 2. Who could be affected - All residents have the potential to be affected by this deficient practice. 3. How we are monitoring - The Maintenance Director received 1:1 inservice training on 4/25/14</td>
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<td>05/10/2018</td>
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### Statement of Deficiencies and Plan of Correction

**Identification Number**: MULTIPLE CONSTRUCTION

**Date Surveyed**: 04/10/2018

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**Provider Name**: WATERS OF INDIANAPOLIS, THE

**Address**: 3895 S KEYSTONE AVE, INDIANAPOLIS, IN 46227

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**Summary Statement of Deficiency**: The documentation provided a weekly check of each resident room battery operated smoke detector location for eleven of the most recent twelve months but did not indicate if the check was testing or cleaning or both. Based on interview at the time of record review, the Maintenance Supervisor stated the weekly check was for testing smoke detectors, a recent water leak in the Maintenance Office destroyed some life safety records and agreed battery operated smoke detector testing and cleaning documentation for the aforementioned monthly periods was not available for review at the time of the survey.

Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, battery operated smoke detectors are installed in each resident room. Manufacturer's documentation affixed to the battery operated smoke detector in resident Room L2 stated it was First Alert Model 0827 and to test the detector weekly and to clean the detector monthly. Based on interview at the time of the observations, the Maintenance Supervisor stated the same model smoke detector is installed in each resident sleeping room.

3.1-19(b)

**Provider's Plan of Correction**: QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Maintenance Director 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.

**Date of Compliance**: May 10th 2018

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<td>K 0363</td>
<td>SS=E Bldg. 01</td>
<td>related to this deficient practice. An audit of any other comparable issues related to this deficient practice will be conducted throughout the facility. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Maintenance Director 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.</td>
<td>04/10/2018</td>
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**NFPA 101**

**Corridor - Doors**

**Corridor - Doors**

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
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<tr>
<td>K 0363</td>
<td>K 363 -</td>
<td>05/10/2018</td>
<td>Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room.</td>
<td>1. What we did - The Maintenance Director will adjust the hinges of the door to the entrance of the Therapy room to eliminate the gap.</td>
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Findings include:

Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, a one half inch gap between the top of the door and the door jamb on the handle side of the door was noted in the corridor door to the Therapy Room when the door was closed and latched. Based on interview at the time of observation, the Maintenance Supervisor agreed the aforementioned gap in between the corridor door to the Therapy Room and the door jamb would not resist the passage of smoke when fully closed and latched.

3-1.19(b)

Based on record review, observation and interview; the facility failed to ensure 4 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in order to resist passage of smoke when fully closed and latched.

2. Who could be affected - All residents have the potential to be affected by this deficient practice.

3. How we are monitoring - The Maintenance Director received 1:1 inservice training on 4/25/14 related to this deficient practice. An audit of any other comparable issues related to this deficient practice will be conducted throughout the facility. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Maintenance Director 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.

4. Date of Compliance - May 10th 2018

NFPA 101 Building Services - Other Building Services - Other

List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.

Based on record review, observation and interview; the facility failed to ensure 4 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in order to resist passage of smoke when fully closed and latched.

K 0500 - What we did

1. What facility will acquire current certificates of inspection posted
**Safe Operating Condition**

NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, 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.

**Findings Include:**

Based on record review with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, current Certificate of Inspection documentation from the State of Indiana was not available for review. Based on interview at the time of record review, the Administrator stated one of four service water heaters had an inspection to obtain an updated Certificate but inspection and current Certificate of Inspection documentation was not available for review at the time of the survey.

Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, the following four water heaters had expired Certificate of Inspection documentation from the State of Indiana posted at the water heater location:

- a. the service water heater identified as IN266181 had a Certificate of Inspection posted at the unit stating the expiration date was 11/18/15.
- b. the service water heater identified as IN338686 had a Certificate of Inspection posted at the unit stating the expiration date was 09/28/17.
- c. the service water heater identified as IN338657 had a Certificate of Inspection posted at the unit stating the expiration date was 11/18/15.
- d. the service water heater identified as IN316808 had a Certificate of Inspection posted at the unit stating the expiration date was 11/18/15.

**Corrective Action Plan**

1. The Maintenance Director received 1:1 inservice training on 4/25/14 related to this deficient practice. An audit of any other comparable issues related to this deficient practice will be conducted throughout the facility. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Maintenance Director 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.

2. Who could be affected - All residents have the potential to be affected by this deficient practice.

3. How we are monitoring - The Maintenance Director received 1:1 inservice training on 4/25/14 related to this deficient practice.

4. Date of Compliance - May 10th 2018
Based on interview at the time of the observations, the Administrator and Maintenance Supervisor stated documentation of current Certificate of Inspection is kept in no other location than at the service water heater locations and agreed the aforementioned service water heaters had expired Certificate of Inspection documentation from the State of Indiana.

3.1-19(b)

NFPA 101

Fire Drills

Fire Drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7

Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the second and third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors.

Findings include:

Based on review of "Fire Drill Report" and "Fire Drill Schedule" documentation with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, documentation of a fire drill conducted on the second and third shift in the

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<tr>
<td>K 0712</td>
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<td>Bldg. 01</td>
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1. What we did - The facility will conduct and document fire drills at expected and unexpected times under varying conditions and at least quarterly on each shift and a schedule will be created to document these drills.

2. Who could be affected - All residents have the potential to be affected by this deficient practice.

3. How we are monitoring - The Maintenance Director received 1:1
second quarter (April, May, June) of 2017 was not available for review. Based interview at the time of record review, the Maintenance Supervisor stated a recent water leak in the Maintenance Office destroyed some life safety records and documentation of a fire drill conducted on the aforementioned shifts in the second quarter of 2017 was not available for review.

3.1-19(b)

NFPA 101
Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.

Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent inservice training on 4/25/14 related to this deficient practice. An audit of any other comparable issues related to this deficient practice will be conducted throughout the facility. QA will continually monitor for comparable deficiencies related to this deficient practice for 6 months. This monitoring will be completed by the Maintenance Director 1 time per week for 3 months or until the issue is remedied and approved by the QA team to ensure ongoing compliance.

4. Date of Compliance - May 10th 2018
personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

1. Based on observation and interview, the facility failed to ensure 1 of 1 automatic transfer switches was maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, Section 6.2.16.2 states two pilot lights with identification nameplates or other approved position indicators shall be provided to indicate the switch position. This deficient practice could affect all residents, staff and visitors.

Findings include:

Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, neither position indicator for the automatic transfer switch located in the generator room inside the Maintenance Office was illuminated to indicate the switch position. One pilot position was listed as "Normal" and the second pilot was listed as "Emer." Based on interview at the time of the observations, the Maintenance Supervisor stated the automatic transfer switch is operable.

1. What we did –
   a. The facility has contacted Safecare and the lights to the transfer switch have been repaired and appropriately illuminate.
   b. The facility has created a monthly and annually functional testing log for the emergency lighting located in the Emergency Generator room.
   c. Citizens Gas has been contacted and a letter was received stating that Citizens Gas is a reliable source of energy.

2. Who could be affected? - All residents have the potential to be affected by this deficient practice.

3. How we are monitoring - The facility will review the Emergency Operations Plan to identify any other sections that have not been included. QA will continually...
and did transfer building power to the generator
during the March 2018 load test but agreed
neither position indicator for the automatic
transfer switch was illuminated to indicate the
switch position.

3.1-19(b)

2. Based on record review, observation and
interview; the facility failed to ensure 1 of 1
emergency task generator battery backup lights
was maintained in accordance with NFPA 110.
NFPA 110, Standard for Emergency and Standby
Power Systems, 2010 Edition, Section 7.3.1
requires the Level 1 or Level 2 EPS equipment
location(s) shall be provided with
battery-powered emergency lighting. This
requirement shall not apply to units located
outdoors in enclosures that do not include walk-in
access. LSC Section 7.9.3.1.1 states required
emergency lighting systems shall be tested as
follows: (1) functional testing shall be conducted
monthly, with a minimum of 3 weeks and a
maximum of 5 weeks between tests, for not less
than 30 seconds, (3) Functional testing shall be
conducted annually for a minimum of 1 1/2 hours
if the emergency lighting system is battery
powered and (5) Written records of visual
inspections and tests shall be kept by the owner
for inspection by the authority having
jurisdiction. This deficient practice could affect all
residents, staff and visitors in the facility.

Findings include:

Based on record review with the Administrator
and the Maintenance Supervisor during record
review from 9:00 a.m. to 11:40 a.m. on 04/10/18,
monthly and annual functional testing for the
battery powered lighting system located in the
monitor for comparable
deficiencies related to this
deficient practice for 6 months.
This monitoring will be completed by the Administrator 1 time per
week for 3 months or until the
issue is remedied and approved by
the QA team to ensure ongoing
compliance.

4. Date of Compliance - May 10th
2018
generator room inside the Maintenance Office was not available for review. Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, one battery powered lighting system located in the generator room inside the Maintenance Office which did not function when its respective test button was pushed five separate times. Based on interview at the time of record review and of the observations, the Maintenance Supervisor stated the monthly and annual functional testing documentation for the lighting system was not available for review.

3.1-19(b)

3. Based on record review, observation and interview; the facility failed to ensure the reliable source documentation for the off site fuel source for 1 of 1 emergency generators included a statement of reasonable reliability of the natural gas delivery, the history and probability of an interruption of service and was signed by a person with the technical expertise to make the reliable source claim. NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems, Chapter 5, Emergency Power Supply (EPS), 5.1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):

(1) Liquid Petroleum products at atmospheric pressure
(2) Liquefied petroleum gas (liquid or vapor withdrawal)
(3) Natural or synthetic gas

Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall
be required, with provision for automatic transfer from the primary energy source to the alternate energy source.

CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:
1. A statement of reasonable reliability of the natural gas delivery.
2. A brief description that supports the statement regarding the reliability.
3. A statement that there is a low probability of interruption of the natural gas.
4. A brief description that supports the statement regarding the low probability of interruption,
5. The signature of a technical person from the natural gas provider.

This deficient practice could affect all residents, staff and visitors.

Findings include:

Based on record review with the Administrator and the Maintenance Supervisor during record review from 9:00 a.m. to 11:40 a.m. on 04/10/18, a natural gas reliability letter from the off site fuel supplier for the facility's emergency generator was not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Supervisor stated the fuel source for the emergency generator was natural gas and agreed a natural gas reliability letter from the off site fuel provider was not available for review. Based on observations with the Administrator and the Maintenance Supervisor during a tour of the facility from 11:40 a.m. to 1:15 p.m. on 04/10/18, one natural gas fired generator rated at 15 kW was noted in the generator room inside the Maintenance Office.
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<th>X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER</th>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

**DATE SURVEY COMPLETED**

**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**SUMMARY STATEMENT OF DEFICIENCY**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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**COMPLETION DATE**

**CROSS-REFERENCED TO THE APPROPRIATE**

**INDIANAPOLIS, IN 46227**

WATERS OF INDIANAPOLIS, THE

3895 S KEYSTONE AVE