

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/24/2016
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NAME OF PROVIDER OR SUPPLIER  WATERS OF NEW CASTLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362
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K 0000  Bldg. 01	<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: 05/24/16</p> <p>Facility Number: 000201 Provider Number: 155304 AIM Number: 100267910</p> <p>At this Life Safety Code survey, The Waters of New Castle 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>The Waters of New Castle was located on the third floor of a four story sprinkled hospital with a basement and was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident</p>	K 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request a desk review in lieu of post re-certification on or after 6.23.16.</p>	
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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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K 0011 SS=F Bldg. 01	<p>sleeping rooms. The facility has a capacity of 66 and had a census of 48 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the communication room. The facility had one detached building housing the 208 emergency generator which is not sprinkled.</p> <p>Quality Review completed on 05/27/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers to nonconforming buildings was protected by a two hour fire wall. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0011	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible evidence and request</p>	06/23/2016			

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	<p>facility with the Maintenance Supervisor on 05/24/16 at 11:30 p.m., above the ceiling tiles of the firewall which separates the nursing facility from the Henry County Hospital office space had missing sections of drywall on the nursing facility ' s side. There was a four foot by five foot incomplete section of drywall and (five) two by two inch holes throughout the drywall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurement of the missing drywall sections.</p> <p>3.1-19(b)</p>		<p>a desk review in lieu of post re-certification on or after 6.23.16.</p> <p>K-011 NFPA 101 Life Safety Code Standard</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 ½ hour fire resistance rating.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>By 6.17.16 the four foot by five foot section of drywall, and (five) two by two inch holes throughout the drywall wall be replaced and corrected.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by the deficient practice. By 6.17.16 the four foot by five foot section of drywall, and (five) two by two inch</p>	

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			<p>holes throughout the drywall wall be replace and corrected.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>Maintenance staff was educated on fire barrier walls on 6.7.16. Noncompliance with Life Safety code K-11 may result in employee re-education, and/or disciplinary action up to and including termination. The maintenance director will monitor fire barrier walls; areas of non-compliance are addressed with maintenance and corrected.</p> <p>Maintenance staff members are educated on fire barrier walls upon hire and as needed.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The Director of Maintenance is responsible for compliance with firewall. A Quality Improvement Data Collection Form audit tool will be utilized weekly x 4, monthly x 6, to monitor compliance for fire wall.</p>	

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K 0020 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 Based on observation and interview, the facility failed to ensure 1 of 3 exit stairways were enclosed with construction providing a fire resistance of at least 1 hour and shall be self-closing. This deficient practice could affects up to 15 residents in one of four smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/24/16 at 10:30 a.m., the fire rating for stairway door to stairwell number one had a label that was painted over and the fire rating could not be determined. Based on interview at the time observation, the Maintenance Supervisor acknowledged the paint on the label was</p>	K 0020	<p>The governing QAP I committee overseen by the Executive Director will review the data. If the threshold for compliance is not met, an action plan will be developed.</p> <p><b>K-020 NFPA Life Safety Code Standard Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The fire rating label on the stairway door to stairwell number one has been cleaned and is able to be viewed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Up to 15 residents in one of the four smoke compartments have the potential to be affected by the</b></p>	06/23/2016

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	covering the fire rating of the door.  3.1-19(b)		deficient practice. The fire rating label on the stairway door to stairwell number one has been cleaned and is able to be viewed. <b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b> Maintenance staff was educated on fire door ratings on 6.7.16. Noncompliance with Life Safety code K-20 may result in employee re-education, and/or disciplinary action up to and including termination. The maintenance director will monitor fire door ratings; areas of non-compliance are addressed with maintenance and corrected. Maintenance staff members are educated on fire door ratings upon hire and as needed. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Director of Maintenance is responsible for compliance with smoke doors. A Quality Improvement Data Collection Form audit tool will be utilized weekly x 4, monthly x 6, to monitor compliance for smoke doors. The governing QAPI committee overseen by the Executive Director will review the data. If the threshold for compliance is not met, an action plan will be developed.		

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K 0025 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect up to 35 residents in 3 of 4 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0025	<p><b>K-025NFPA 101 Life Safety Code Standard</b> <b>Smokebarriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wire glass panels and steel frames. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Fire caulk has been applied to; A). Above the ceiling tiles of the smoke barrier wall by the reception office there were two unsealed one inch penetration around wires. B). Above the ceiling tiles of the smoke barrier wall by room 304 there were two unsealed one inch penetration around wires and C). Above the ceiling tiles of the smoke barrier wall by room 342 there were two unsealed one inch penetration</p>	06/23/2016
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	<p>facility with the Maintenance Supervisor on 05/24/16 between 11:30 a.m., and 12:15 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) Above the ceiling tiles of the smoke barrier wall by the reception office there were two unsealed one inch penetration around wires.</p> <p>b) Above the ceiling tiles of the smoke barrier wall by room 304 there were two unsealed one inch penetration around wires.</p> <p>c) Above the ceiling tiles of the smoke barrier wall by room 342 there were two unsealed one inch penetration around wires.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p>		<p>around wires to maintain the smoke barrier walls.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>This deficient practice could affect up to 35 residents and fire caulk has been applied to; A). Above the ceiling tiles of the smoke barrier wall by the reception office there were two unsealed one inch penetration around wires. B). Above the ceiling tiles of the smoke barrier wall by room 304 there were two unsealed one inch penetration around wires and C). Above the ceiling tiles of the smoke barrier wall by room 342 there were two unsealed one inch penetration around wires to maintain the smoke barrier walls.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>Maintenance staff was educated on smoke barrier walls on 6.7.16. Noncompliance with Life Safety code K-25 may result in employee re-education, and/or</p>		

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K 0034 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3,		<p>disciplinary action up to and including termination. The maintainedirector will monitor smoke barrier walls; areas of non-compliance areaddressed with maintenance and corrected.</p> <p>Maintenance staff members are educated on smoke barrier walls uponhire and as needed.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficientpractice will not recur, i.e., what quality assurance program will be put intoplace?</b></p> <p>The Director of Maintenance is responsible for compliance with smokebarrier walls. A Quality Improvement Data Collection Form audit tool will beutilized weekly x 4, monthly x 6, to monitor compliance for smoke barrierwalls.</p> <p>The governing QAPCommittee overseen by the Executive Director will review the data. If thethreshold for compliance is not met, an action plan will be developed.</p>	

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	<p>18.2.2.4, 19.2.2.3, 19.2.2.4</p> <p>Based on observations and interview, the facility failed to ensure items stored in 1 of 3 exit stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any open space within the enclosure shall not be used for any other purpose which could interfere with egress. This deficient practice could affect up to 15 residents using stairwell number one for evacuation.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 05/24/16 at 10:10 a.m., the bottom of stairwell number one was used to store construction supplies. Based on interview at the time observation, the Maintenance Supervisor acknowledged that construction supplies were being stored in stairwell number one.</p> <p>3.1-19(b)</p>	K 0034	<p>K-034 NFPA 101 Life Safety Code Standard</p> <p>Stairways and smoke proof enclosures used as exits are in accordance with egress.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The construction items being stored in the bottom of stairwell number one have been moved so that they would not interfere with egress.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>This deficient practice could affect up to 15 residents using stairwell number one for evacuation. The construction items being stored in the bottom of stairwell number one have been moved so that they would not interfere with egress.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p>	06/23/2016			

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			<p>Maintenance staff was educated on stairway egress on 6.7.16. Noncompliance with Life Safety code K-34 may result in employee re-education, and/or disciplinary action up to and including termination. The maintenance director will monitor stairway egress; areas of non-compliance are addressed with maintenance and corrected.</p> <p>Maintenance staff members are educated on stairway egress ratings upon hire and as needed.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>The Director of Maintenance is responsible for compliance with egress in stairwells. A Quality Improvement Data Collection Form audit tool will be utilized weekly x 4, monthly x 6, to monitor compliance for egress in stairwells.</p> <p>The governing QAPI committee overseen by the Executive Director will review the data. If the threshold for compliance is not met, an action plan will be developed.</p>	

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K 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal to monitoring company for 8 of 12 fire drills conducted. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review of the fire drill forms with the Maintenance Supervisor on 05/24/16 at 12:20 p.m., the documentation for eight of the twelve fire drills conducted between the hours of 6 a.m. and 9 p.m. lacked the verification fire alarm signal to monitoring company. Based on interview, this was confirmed by the Maintenance Supervisor at the time of record review.</p>	K 0050	<p><b>K-050NFPA 101 Life Safety Code Standard FireDrills included transmission of a fire alarm signal and simulation of emergencyfire conditions. Fire drills are held at unexpected times under varyingconditions, at least quarterly on each shift. The staff is familiar withprocedures and is aware that drills are part of established routine.Responsibility for planning and conducting drills is assigned only to competentpersons who are qualified to exercise leadership. Where drills are conductedbetween 9pm and 6am a code announcement may be used instead of audible alarms. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the</b></p>	06/23/2016

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	3.1-19(b) 3.1-51(c)		<p><b>deficient practice?</b> A fire alarm signal was sent to the monitoring company to ensure signal was received. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> All residents have the potential to be affected by this deficient practice and a fire alarm signal was sent to the monitoring company to ensure signal was received. <b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b> Maintenance staff was educated on fire drills on 6.7.16. Noncompliance with Life Safety code K-50 may result in employee re-education, and/or disciplinary action up to and including termination. The maintenance director will monitor fire drills; areas of non-compliance are addressed with maintenance and corrected. Maintenance staff members are educated on fire drills upon hire and as needed.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Director of Maintenance is responsible for compliance with doors protecting corridor openings. A Quality</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/24/2016
NAME OF PROVIDER OR SUPPLIER  WATERS OF NEW CASTLE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
			Improvement Data Collection Form audit tool will be utilized weekly x 4, monthly x 6, to monitor compliance for doors protecting corridor openings. The governing QAPI committee overseen by the Executive Director will review the data. If the threshold for compliance is not met, an action plan will be developed.		