

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |
|---|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

|                        |  |        |   |  |
|------------------------|--|--------|---|--|
| K 0000<br><br>Bldg. 02 | <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: 07/22/15-07/23/15</p> <p>Facility Number: 000178<br/>Provider Number: 155280<br/>AIM Number: 100273840</p> <p>At this Life Safety Code survey, The Waters of Dillsboro-Ross Manor 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 and 410 IAC 16.2. The original Waters of Dillsboro building and Ross Manor buildings were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The Waters of Dillsboro-Ross Manor consisted of two separate buildings. The Waters of Dillsboro, a two story facility was determined to be of Type II (000) construction with a basement and fully sprinkled. Ross Manor, a one story</p> | K 0000 | Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or 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 law. This plan of correctin constitutes our credible allegation of compliance with regulatory requirements.Our date of compliance is August 21, 2015. |  |
|------------------------|--|--------|---|--|

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.

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |
|---|--|

| (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 |
|----------------------------|---|---------------|---|----------------------|
| K 0012<br>SS=F<br>Bldg. 02 | <p>facility was determined to be Type V (111) construction and fully sprinkled. Both facilities have a fire alarm system with smoke detection on all levels of the Waters of Dillsboro building and Ross Manor building including the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms in the Waters of Dillsboro building and the Ross Manor building. The Waters of Dillsboro-Ross Manor has a capacity of 123 and had a census of 90 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.</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 floors was constructed with a 1 hour rated floor structure. This deficient practice affects 64 residents who reside in the Waters of Dillsboro building.</p> <p>Findings include:</p> | K 0012        | Please see attached Life Safety Code Waiver request letter. Please see attached FP&C summary report. A. ACTION TAKEN: FP&C Consultants, Inc. were retained to evaluate the building through the Fire Safety Evaluation System (FSES). Dennis Bradshaw conducted building survey on August 11, | 08/21/2015           |

|   |  |   |  |  |  |   |                      |
|---|--|---|--|--|--|---|----------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____              |  | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |                      |
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |  |   |                      |
| (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 |
| K 0014<br>SS=E<br>Bldg. 02  | <p>Based on a tour of the Waters of Dillsboro building basement on 07/23/15 from 8:20 a.m. to 10:30 a.m. with the maintenance supervisor and assistant maintenance supervisor, the basement to first floor was separated with exposed wood floor joists throughout the entire basement with no interior finish covering the wooden floor joists. The basement was used as a maintenance workshop, storage location, and laundry. Based on an interview with the assistant maintenance supervisor on 07/23/15 at 8:45 a.m., the first floor is constructed of one half inch plywood with vinyl flooring throughout the first floor with no fire rated material. The basement ceiling lacking one hour construction was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/23/15 at 12:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B.<br/>19.3.3.1, 19.3.3.2</p> |   |  |  | <p>2015. Upon completion of all minor deficiencies noted, the FSES has determined that the level of fire safety is at least equivalent to that prescribed by NFPA 101 , Life Safety Code, for existing health care facilities.<br/>B.OTHERS IDENTIFIED: None<br/>C.MEASURES TAKEN: No further recommendations D.HOW MONITORED: 1. The maintenance supervisor/designee will continue to monitor life safety code in the facility as required by regulations. 2. Any changes to the structure of the bulding will be reported to life safety for review to stay with in the required standards of the building. E.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 21, 2015.</p> |   |                      |

|   |   |   |  |  |  |   |  |
|---|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____              |  | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |  |   |  |
| (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   |  |   |  |
|   | <p>Based on observation and interview, the facility failed to ensure 1 of 7 exit ways in the Waters of Dillsboro building was provided with an interior finish with a flame spread rating of Class A or Class B. This deficient practice could affect 18 residents who reside on the second floor West Hall and would use the second floor West Hall stairway corridor for an exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 07/23/15 at 11:45 a.m. with the maintenance supervisor and assistant maintenance supervisor, the Waters of Dillsboro building second floor West Hall stairway corridor south wall at the top of the stairway was covered with a wood paneling interior finish. Based on an interview with the assistant maintenance supervisor on 07/23/15 at 11:50 a.m., there is no documentation to indicate the flame spread rating of the wood paneling second floor stairway wall interior finish. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/23/15 at 12:00 p.m.</p> <p>3.1-19(b)</p> | K 0014  | <p>A.ACTION TAKEN: The exit way wall on the second floor West Hall was covered with an interior finish with a flame spread rating of Class A or Class B.</p> <p>B.OTHERS IDENTIFIED: 100% audit of all appropriate interior walls was performed. No other areas identified. C.MEASURES TAKEN: The maintenance supervisor/designee will inspect all applicable interior walls to ensure that requirements for fire safety are met during monthly maintenance program and PRN.</p> <p>D:HOW MONITORED: Any areas found will be immediately corrected and brought to the next CQI meeting for discussion. Results will be monitored and reviewed at the monthly and quarterly QA meetings to determine ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. OUR date of compliance is August 21,2015.</p> | 08/21/2015   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____              |  | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |  |
|---|--|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |  |   |  |
| (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   |  |   |  |
| K 0020<br>SS=E<br>Bldg. 02  | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to maintain the vertical opening protection for 1 of 2 elevator shafts. LSC 8.2.5.2 requires enclosure of vertical openings including stairwells with fire barrier walls with a fire resistance rating of at least one hour. This deficient practice could affect 20 residents who reside on the first floor Chapel Hall near the old elevator.</p> <p>Findings include:</p> <p>Based on observation on 07/23/15 at 8:50 a.m. with the maintenance supervisor and assistant maintenance supervisor, the basement elevator equipment room had two, three inch gaps around hydraulic lines leading into the old elevator shaft not fire stopped. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/23/15 at 12:00 p.m.</p> | K 0020  | <p>A.ACTION TAKEN: The two, three inch gaps around the hydraulic lines leading into the old elevator shaft on the first floor were fire stopped. B.OTHERS IDENTIFIED: 100% audit done on old elevator to ensure no other areas were identified. No other areas identified. C.MEASURES TAKEN: The maintenance/designee will inspect all applicable areas as part of the monthly maintenance program. D.HOW MONITORED: 1.Any areas found will be immediately corrected and brought to the next CQI meeting for discussion. 2.Results will be monitored at the monthly and quarterly QA meeting to determine ongoing monitoring. E.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 21, 2015.</p> | 08/21/2015   |  |   |  |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |
|---|--|

| (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 |
|----------------------------|---|---------------|---|----------------------|
| K 0029<br>SS=E<br>Bldg. 02 | <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 second floor hazardous areas, such as a combustibile storage room over 50 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frames. This deficient practice could affect 16 residents who reside on the second floor West Hall near the nurses' station.</p> <p>Findings include:</p> <p>Based on observation on 07/23/15 at 11:20 p.m. with the assistant maintenance supervisor, the second floor West Hall storage room, which measured seventy</p> | K 0029        | <p>A.ACTION TAKEN: Storage room door on second floor by nurses station was replaced and a self closing device was applied. B.OTHERS IDENTIFIED: 100% audit on hazardous area doors were conducted. No other doors identified. C.MEASURES TAKEN: The maintenance/designee will inspect all applicable doors to ensure they are equipped with self closing devices. Any areas of concern will be immediately corrected and brought to next CQI meeting for discussion. D.HOW MONITORED: Results will be monitored and reviewed at the monthly and quarterly QA meetings to determine ongoing monitoring. E.This plan of correction constitutes our credible allegation of compliance with all</p> | 08/21/2015           |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |
|---|--|

| (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 |
|----------------------------|--|---------------|--|----------------------|
| K 0147<br>SS=E<br>Bldg. 02 | <p>two square feet and had combustible storage consisting of six cardboard boxes of plastic adult briefs and eight plastic tubs, lacked a self closing device on the door. This was verified by the assistant maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/23/15 at 12:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 67 wet location resident care areas in the Waters of Dillsboro building were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit</p> | K 0147        | <p>regulatory requirements. Our date of compliance is August 21, 2015</p> <p>A.ACTION TAKEN:<br/>1.Maintenance/designee removed the two GFCI's and covered them with a blank plate. They are no longer in use. 2.All extension cords and surge protectors that were being used for resident equipment were removed. All medical devices were plugged into wall sockets. B.OTHERS IDENTIFIED: 1.No other areas were identified. 2.100% audit of all medical equipment was conducted in the Dillsboro building to ensure that no other medical equipment was connected to extension cords or surge protectors. No other areas were identified. C.MEASURES TAKEN: 1.The maintenance/designee will inspect all GFCI's for proper</p> | 08/21/2015           |

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____              |  | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |  |   |  |
| (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   |  |   |  |
|   | <p>interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects 2 residents who reside in resident room 50 and staff that uses the first floor East Hall soiled linen room.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor and assistant maintenance supervisor on 07/23/15 during a tour of the Waters of Dillsboro building from 8:00 a.m. to 12:00 p.m., the first floor East Hall soiled linen room and second floor resident room 50 each had one electrical outlet within two feet of the wash tub and hand wash sink with no ground fault circuit interrupters on the electric outlets. Based on observation of the main electrical breaker panels with the maintenance supervisor and assistant maintenance supervisor at the time of observations, the circuit breakers for the electric outlets were not provided with GFCI protection. This was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/23/15 at 12:00 p.m.</p> |   | <p>ground fault circuit interrupters during monthly maintenance program and PRN. Any areas found will be immediately corrected and will be brought to the next CQI meeting for discussion. 2.The maintenance/designee will audit resident rooms during monthly maintenance program and PRN to ensure no medical equipment is connected to extension cords and/or surge protectors. Any areas found will be immediately corrected and will be brought to the next CQI meeting for discussion. D.HOW MONITORED: 1.All results will be monitored and reviewed at the monthly and quarterly QA meetings for determination of ongoing monitoring. E.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 21, 2015.</p> |  |  |   |  |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |
|---|--|

| (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 |
|--------------------|---|---------------|---|----------------------|
|                    | <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring in 5 of 76 resident rooms in the Waters of Dillsboro building. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 10 residents who resident in resident rooms 3, 11, 23, 44, and 51 in the Waters of Dillsboro building.</p> <p>Findings include:</p> <p>Based on observations on 07/23/15 during the tour of the Waters of Dillsboro building with the maintenance supervisor and assistant maintenance supervisor from 8:00 am to 12:00 p.m., the following locations used either power strips or extension cords:</p> <p>a) Resident room 51 used a power strip to power an oxygen concentrator.</p> <p>b) Resident room 23 used a six way multiplug adapter to power a television</p> |               |   |                      |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>02</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |
|---|--|

| (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 |
|------------------------|---|---------------|---|----------------------|
| K 0000<br><br>Bldg. 03 | <p>and fan.</p> <p>c) Resident room 11 used a white thin wire extension cord to power a light fixture next to the bed.</p> <p>d) Resident room 3 used a power strip to power an oxygen concentrator.</p> <p>e) Resident room 44 used a power strip to power an oxygen concentrator.</p> <p>The above listed locations using power strips, multiplug adapters and extension cords was verified by the maintenance supervisor and assistant maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/23/15 at 12:00 p.m.</p> <p>3.1-19(b)</p> <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: 07/22/15-07/23/15</p> <p>Facility Number: 000178<br/>Provider Number: 155280<br/>AIM Number: 100273840</p> | K 0000        | Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or 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 law. This plan of correctin constitutes our credible allegation of compliance |                      |

|  |   |   |   |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>03</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/23/2015 |
|--|---|---|---|

|   |  |
|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018 |
|---|--|

| (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 |
|--------------------|---|---------------|---|----------------------|
|                    | <p>At this Life Safety Code survey, The Waters of Dillsboro-Ross Manor 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 and 410 IAC 16.2. The 2010 Therapy Wing addition, located to the south of the original Ross Manor building and consisted of a single room used for therapy with a two hour separation from the original building, was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2010 Therapy Wing addition to the one story Ross Manor building was determined to be Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 123 and had a census of 90 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.</p> |               | with regulatory requirements. Our date of compliance is August 21, 2015.  |                      |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/21/2015  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155280 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>03</u><br>B. WING _____  |                            | X3) DATE SURVEY<br>COMPLETED<br>07/23/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>WATERS OF DILLSBORO-ROSS MANOR, THE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>12803 LENOVER ST<br>DILLSBORO, IN 47018   |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
|   |  |  |  |                            |  |