

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2011	
NAME OF PROVIDER OR SUPPLIER WATERS OF SEYMOUR, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN47274			
(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			
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/22/11</p> <p>Facility Number: 000272 Provider Number: 155377 AIM Number: 100274710</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Seymour was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and single station smoke detection in all resident sleeping rooms. The facility has</p>	K0000	<p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL, OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p>				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0015 SS=B	<p>a capacity of 100 and had a census of 89 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/25/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Interior finish for rooms and spaces not used for corridors or 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. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 135 room's interior finish had a flame spread rating of Class A, Class B, or Class C. This deficient practice affects 24 residents who reside on the C Wing and use the C Wing shower room.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 at 12:15 p.m. with the administrator and maintenance supervisor, the C Wing shower room had a two foot by four foot</p>	K0015	<p>K-015 It is the intent of this facility that there will be no walls with impairment. A. ACTIONS TAKEN: 1. The wall sections in the B Wing Shower Room will be repaired with drywall. B. OTHERS IDENTIFIED: 1. 100% audit of facility to ensure that there are no further areas requiring drywall repairs. No others were identified. C. MEASURES TAKEN: 1. Maintenance staff in serviced on need to promptly repair areas of wall impairment. D. HOW MONITORED: 1. The Maintenance</p>	09/19/2011	

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K0029 SS=E	<p>section of drywall and a six foot by five foot section of drywall missing on the east wall. Based on an interview with the administrator on 08/22/11 at 12:25 p.m., the C Wing shower room east wall was damaged from a water leak.</p> <p>3.1-19(b)</p> <p>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 doors to 3 of 15 hazardous areas, such as combustible storage rooms over 50 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 36 residents who reside on</p>	K0029	<p>Supervisor/Designee will audit overall facility walls for integrity quarterly for any needed/required repairs. This will be an on-going QA program. 2. The CEO/Designee will monitor for compliance of these repairs in daily QA stand-up meeting. 3. All facility repairs will be reviewed in the quarterly Safety Committee for completion, and the quarterly QA meeting with the Medical Director. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: 9-19-11.</p> <p>K-029 It is the intent of this facility to have self-closing devices on doors to hazardous areas over 50 square feet in size. A. ACTIONS TAKEN: 1. Self-closing devices have been installed on the activity office, A wing storage room, and B wing central supply room doors. B. OTHERS IDENTIFIED: 1. 100% audit of</p>	09/19/2011	

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	<p>the A Wing, located adjacent to the main dining room, and 18 residents who reside on the B Wing.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 during a tour of the A Wing and B Wing with the administrator and maintenance supervisor from 11:20 a.m. to 12:45 p.m., the following combustible storage room doors were not provided with self closing devices;</p> <p>a. The activity office located adjacent to the main dining room, which measured one hundred eighty square feet and stored six shelves of combustible paper, cardboard games, and plastic containers.</p> <p>b. The A Wing storage room, which measured sixty square feet and stored four shelves of combustible plastic and paper nursing supplies.</p> <p>c. The B Wing central supply room, which measured three hundred twelve square feet and stored twenty seven shelves of paper towels, plastic cups, paper napkins, and paper and plastic nursing supplies in cardboard boxes. The administrator and maintenance supervisor at the time of observation acknowledged the doors to the activity office room, the A Wing storage room, and the B Wing central supply room were not provided with self closing devices.</p>		<p>facility to ensure that there are no further areas requiring self-closing devices. No others were identified. C. MEASURES TAKEN: 1. Maintenance staff in serviced on need to have self-closing devices on areas with combustible material and indicated square footage of space. D. HOW MONITORED: 1. The Maintenance Supervisor/Designee will audit areas requiring self-closing devices quarterly for any needed/required repairs. This will be an on-going QA program. 2. The CEO/Designee will monitor for compliance of these repairs in daily QA stand-up meeting. 3. All facility repairs will be reviewed in the quarterly Safety Committee for completion, and the quarterly QA meeting with the Medical Director. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, out date of completion is: 9-19-11.</p>		

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K0062 SS=E	<p>3.1-19(b)</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observations and interview, the facility failed to ensure 2 of 135 rooms were provided with sprinkler heads free of paint and corrosion. 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 36 residents who reside on the A Wing.</p> <p>Findings include:</p> <p>Based on observation on 08/22/11 during a tour of the A Wing with the administrator and maintenance supervisor from 11:20 a.m. to 11:55 a.m., the A Wing nurses' station storage room had one sprinkler covered with green corrosion and the sprinkler in the bathroom of resident room 917 was completely covered with white paint. These were verified by the administrator and maintenance supervisor at the time of observations.</p>	K0062	<p>K-062 It is the intent of this facility to have sprinkler heads that are free from paint or corrosion. A. ACTIONS TAKEN: 1. The sprinkler head in the A Wing nurses' station storage room and bathroom in resident room 917 will be replaced. B. OTHERS IDENTIFIED: 1. 100% audit of facility to ensure that there are no further sprinkler heads with corrosion or paint. No others were identified. C. MEASURES TAKEN: 1. Maintenance staff in serviced on need to keep sprinkler heads free of paint / corrosion. D. HOW MONITORED: 1. The Maintenance Supervisor/Designee will audit sprinkler heads quarterly for any needed/required repairs. This will be an on-going QA program. 2. The CEO/Designee will monitor for compliance of these repairs in daily QA stand-up meeting. 3. All facility repairs will be reviewed in the quarterly Safety Committee for completion, and the quarterly QA meeting with the Medical Director. E. This plan of correction constitutes our</p>	09/19/2011	

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K0147 SS=E	<p>3.1-19(b)</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 33 wet location resident care areas were provided with ground-fault circuit interrupters (GFCI) to prevent electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas 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 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 room 903, two residents who reside in room 908 and two residents who reside in room 918 in the A Wing.</p> <p>Findings include:</p> <p>Based on observations on 08/22/11 during a tour of the A Wing with the</p>	K0147	<p>credible allegation of compliance with all regulatory requirements, out date of completion is: 9-19-11.</p> <p>K-147 It is the intent of this facility to ensure that all outlets in wet areas have ground-fault interrupter protection. A. ACTIONS TAKEN: 1. The outlet in bathrooms of rooms 903, 908, and 918 have been removed / disconnected. B. OTHERS IDENTIFIED: 1. 100% audit of facility to ensure that there are no further outlets in wet locations have ground-fault circuit interrupter (GFCI) protection. No others were identified. C. MEASURES TAKEN: 1. Maintenance staff in serviced on need of GFCI protection when outlets are in wet locations. D. HOW MONITORED: 1. The Maintenance Supervisor/Designee will audit GFCI outlets quarterly for any needed/required repairs. This will be an on-going QA program. 2. The CEO/Designee will monitor for compliance of these repairs in daily QA stand-up meeting. 3. All facility repairs will be reviewed in the quarterly Safety Committee for completion, and the quarterly QA meeting with the Medical Director. E. This plan of correction constitutes our credible allegation of</p>	09/19/2011	

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	<p>administrator and maintenance supervisor from 11:20 a.m. to 11:55 a.m., resident room 903, resident room 908 and resident room 918 each had a light fixture located three feet above the handwashing sink. The light fixtures were each provided with an electric outlet with no visible GFCI protection at the electric outlets. Furthermore, the main electric panels in the A Wing were checked on 08/22/11 at 12:40 p.m. with the maintenance supervisor and it was confirmed the electric receptacles in resident room 903, 908, and 918 light fixtures were not provided with GFCI protection to prevent electric shock. This was verified by the administrator at the 1:20 p.m. exit conference on 08/22/11..</p> <p>3-1-19(b)</p>		<p>compliance with all regulatory requirements, out date of completion is: 9-19-11.</p>		