

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 01/16/2014
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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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K010000	<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: 01/16/14</p> <p>Facility Number: 000201 Provider Number: 155304 AIM Number: 100267910</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</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 sprinklered 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</p>	K010000	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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is February 15, 2014	

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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	<p>all levels including the basement, in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 51 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except the area in the laundry room above the handwash sink, the kitchen north walk-in freezer, and one detached building housing the 208 emergency generator.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 82 room wall smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any of the 26 residents who reside on the 300 East Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 01/16/14 from 9:00 a.m. to 12:40 p.m., the 300 East Hall nurses' storage room east wall had a three inch by two inch area of drywall missing near the floor. Furthermore, the electric equipment room ceiling had two, three inch open electrical conduit pipe penetrations in</p>	K010025	<p>It is the intent of this facility to ensure smoke barriers are constructed to provide at least a one half hour fire resistance rating. 1. Corrective action for affected residents: The ceiling penetrations in the electric equipment room were filled with Fire Barrier Sealant by the Maintenance Supervisor. The missing drywall in the nurses' storage room was repaired by the Maintenance Staff. 2. Other residents with the potential to be affected: Facility found residents residing on this 300 hallway could be affected. 3. Measures to prevent reoccurrence: Maintenance Supervisor/designee will complete monthly audits to ensure fire/smoke barriers are free from openings as part of the preventative maintenance program. 4. Monitoring of corrective action to ensure the practice will not recur: Administrator/designee will review</p>	01/31/2014			

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K010029 SS=A	<p>the ceiling which were open and not firestopped. This was verified by the maintenance supervisor at the time of observations and acknowledged by the director of nursing at the exit conference on 01/16/14 at 12:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 7 hazardous areas, such as combustible storage rooms over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice does not affect any residents, since the kitchen is located on the first floor.</p> <p>Findings include:</p>	K010029	<p>the audit results in the monthly safety meeting and in the facility quarterly QA meeting. 5. Date of compliance: 1/31/2014</p> <p>It is the intent of this facility to ensure corridor doors to storage rooms over 50 square feet in size are provided with self closing devices. 1. Corrective action for affected residents: In regards to the door to the kitchen food storage room, the self closing device was connected to the door frame per Henry County Hospital Maintenance Staff. 2. Other residents with the potential to be affected: Facility has determined no residents were affected since the kitchen is located on the first floor. 3. Measures to prevent</p>	01/30/2014			

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K010056 SS=F	<p>Based on observation on 01/16/14 during a tour of the first floor kitchen with the maintenance supervisor from 12:00 p.m. to 12:40 p.m., the food storage room, which measured three hundred square feet and stored thirty six shelves of combustible cardboard boxes of food and paper products, had a self closing device attached to the door which was disconnected from the door frame. This was verified by the maintenance supervisor at the time of observation and acknowledged by the director of nursing at the exit conference on 01/16/14 at 12:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the</p>	K010056	<p>reoccurrere: Maintenance Superviosr/designee will do a monthly audit as part of the preventative maintenance program of all corridor doors to storage areas to ensure self closing devices are in place. 4. Monitoring of corrective action to ensure the practice will not recur: Administrator/designee will review the audit results in the monthly safety meeting and in the quarterly QA meeting. 5. Date the systematic changes will be completed: 1/30/2014</p> <p>It is the intent of this facility to ensure an automatic sprinkler</p>	02/20/2014			

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	<p>facility failed to ensure 1 of 3 kitchen walk-in coolers and 1 of 82 rooms were completely sprinkled. This deficient practice could affect all residents in the facility in the event of a fire in the centrally located laundry room.</p> <p>Findings include:</p> <p>Based on observations on 01/16/14 during a tour of the facility with the maintenance supervisor from 9:00 a.m. to 12:40 p.m., the third floor laundry room ceiling had a bulkhead which extended one and one half feet down from the ceiling which was blocked sprinkler coverage to the two foot by two foot area above the handwash sink. Furthermore, the first floor north combination walk-in cooler/freezer was not provided with sprinkler coverage in the freezer portion. The lack of sprinkler coverage in the third floor laundry room area above the handwash sink and in the first floor north walk-in freezer was verified by the maintenance supervisor at the time of observations and acknowledged by the director of nursing at the exit conference on 01/16/14 at 12:45 p.m.</p> <p>3.1-19(b)</p>		<p>system provides complete coverage for all portions of the facility. 1. Corrective action for affected resident(s): the third floor laundry room ceiling bulkhead over the handwash sink was removed 1/30/2014. The first floor north freezer section is to have a sprinkler head installed per Henry County Hospital contracting with an outside vendor and is scheduled to be completed 2/20/2014. 2. Other residents with potential to be affected: Facility determined all residents have the potential to be affected. 3. Measures to prevent reoccurrence: Maintenance Supervisor/designee will complete a monthly audit to ensure the sprinkler system provides complete coverage for all portions of the facility as part of the preventative maintenance program. 4. Monitoring of corrective action to ensure the practice will not recur: Administrator/designee will review the audit results in the montly safety meeting and in the facility quarterly QA meeting. 5. Date of compliance: 2/20/2014</p>				

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K010147 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 1 of 40 wet location resident care areas was 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 interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice does not affect any residents, but does affect staff who use the nourishment room sink.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 01/16/14 at 10:50 a.m., the staff nourishment room had an electric receptacle on the wall</p>	K010147	<p>It is the intent of this facility to ensure electrical outlets near a sink are provided with ground fault circuit interrupter protection against electric shock. 1. Corrective action for affected residents: In regards to the outlet within 4 feet of the sink in the nourishment room, the outlet was removed. 2. Other residents with potential to be affected: No residents were affected. 3. Measures to prevent reoccurrence: Maintenance Supervisor/designee will do monthly audit as part of the preventative maintenance program of all outlets near a sink to ensure the placement of GFCI protective device. 4. Monitoring of corrective action to ensure the practice will not recur: Administrator/designee will review the audit results in the monthly safety meeting and in the quarterly QA meeting. 5. Date systematic change will be completed: 1/30/2014</p>	01/30/2014			

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	<p>within four feet of the sink which was not provided with a ground fault circuit interrupter. Furthermore, the main electrical panel serving the area which was located in the main electric room by elevator #3 was observed, and it was not provided with a ground fault circuit interrupter breaker. Based on an interview with the maintenance supervisor on 01/16/14 at 11:35 a.m., the nourishment room sink is only used by staff to make morning coffee. The lack of a ground fault circuit interrupter at the electric outlet in the nourishment room was verified by the maintenance supervisor at the time of observation and confirmed by the director of nursing at the exit conference on 01/16/14 at 12:45 p.m.</p> <p>3.1-19(b)</p>			