

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  10/09/2012
--	---	--	---

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
K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/09/12</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 located on the third floor of a four story sprinklered hospital with a basement was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection on all levels including</p>	K0000	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 November 8, 2012	

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:  155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

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
	<p>the basement, the corridors, 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 50 at the time of this visit.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached building housing the 208 emergency generator which is not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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  10/09/2012	
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			
K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 95 corridor doors would latch and resist the passage of smoke. This deficient practice affects one resident who resides in resident room # 362, and 5 residents who reside in the smoke compartment containing rooms # 332 to room # 340.</p> <p>Findings include:</p> <p>Based on observations on 10/09/12 during a tour of the facility from 11:58 a.m. to 1:40 p.m. with the maintenance supervisor and hospital director of plant operations, resident room door # 362 had a one half inch gap along the entire latching side of the door in the closed position, and the supply room door had a</p>	K0018	<p>It is the intent of this facility the ensure corridor doors will latch and resist the passage of smoke. I. Corrective Action for affected residents: 1. In regards to the door closure for resident room #362, this door is to have the latching device replaced per Henry County Hospital maintenance staff to ensure closure and resistance of the passage of smoke. 2. In regards to door for supply room in compartment containing rooms #332- #340, the three inch diameter hole was filled with fire resistant putty. II. Other residents with potential to be affected: 1. Environment Supervisor completed an audit for doors protecting corridor openings to ensure sufficient closing and lack of unsealed openings (holes), no areas of concern noted. III.</p>	11/08/2012			

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  10/09/2012
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	
	<p>three inch diameter hole where the old latching hardware was replaced. The resident room # 362 door gap and the supply room door three inch diameter hole were verified by the maintenance supervisor at the time of observations and confirmed by the director of nursing at the 1:40 p.m. exit conference on 10/09/12.</p> <p>3.1-19(b)</p>		<p>Measures to prevent reoccurrence: 1. Environmental Supervisor/Designee to do monthly audit as part of the preventative maintenance program of all corridor doors to ensure complete closer and door condition to prevent the passage of smoke. IV. Monitoring of corrective action to ensure the practice will not recur: 1. Administrator/designee will review the audit results in the monthly safety meeting and quarterly in the facility QA meeting. V. Date completed: 11/8/2012</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  10/09/2012	
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			
K0029 SS=E	<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 doors to 2 of 7 hazardous areas such as combustibile 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 7 residents who reside in the smoke compartment containing the rooms # 370 to room # 382.</p> <p>Findings include:</p> <p>Based on observations on 10/09/12 during a tour of the facility from 11:58 to 1:40 p.m. with the maintenance supervisor and hospital director of plant operations, the following combustibile storage room doors were not provided with self closing devices;</p> <p>a. The door to the storage room by</p>	K0029	<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. I. Corrective action for affected residents: 1. In regards to storage room by elevator #3, a self closing device is to be installed per Henry County Hospital maintenance staff. 2. In regards to the door to the kitchen food storage room, a self closing device is to be installed per Henry County Hospital maintenance staff. II. Other residents with potential to be affected: 1. Environmental Supervisor completed an audit for all corridor doors to storage areas to ensure placement of self closing devices. No areas of concern noted. III. Measure to prevent reoccurrence: 1. Environment Supervisor/designee will do monthly audit as part of the preventative maintenance program of all corridor doors</p>	11/08/2012			

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  10/09/2012
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	
	<p>elevator # 3 which measured one hundred forty four square feet and stored six combustible cardboard boxes of paper and nursing supplies, was not provided with a self closing device.</p> <p>b. The door to the kitchen food storage room which measured three hundred sixty square feet and stored thirty eight combustible cardboard boxes of paper and plastic food supplies, was not provided with a self closing device. The lack of self closing devices on the door to the storage room by elevator # 3 and the door to the food storage room was verified by the maintenance supervisor at the time of observations and acknowledged by the director of nursing at the 1:40 p.m. exit conference on 10/09/12.</p> <p>3.1-19(b)</p>		<p>to storage areas to ensure self closing devices are in place. IV. Monitoring of corrective action to ensure the practice will not recur:</p> <p>1. Administrator/designee will review the audit results in the monthly safety meeting and quarterly in the facility QA meeting. V. Date completed: 11/8/2012</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  10/09/2012
--	---	--	---

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
K0048 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to include the use of kitchen K-class portable fire extinguisher in 1 of 1 written fire safety plans to protect residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects mainly staff in the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire disaster plan labeled Life Safety Management Plan Fire Extinguishers on 10/09/12 at 1:00 p.m. with the maintenance supervisor and hospital safety officer, the written plan did not address the use of the kitchen K-class fire</p>	K0048	<p>It is the intent of this facility to include the use of kitchen K-class portable fire extinguisher in the written fire safety plan. I. Corrective action for affected residents: 1. Henry County Hospital included the use of kitchen K-class portable fire extinguisher in the written fire safety plan. II. Other residents with potential to be affected: 1. No residents were affected. III. Measures to prevent reoccurrence: 1. Administrator/designee to review Henry County Hospital written fire safety plan to confirm inclusion of kitchen K-class portable fire extinguisher. IV. Monitoring of corrective action to ensure the practice will not recur: 1. Administrator/designee will review the written fire safety plan for Henry county Hospital in the monthly safety meeting for 3 months and in the next quarterly facility QA meeting.</p>	11/08/2012

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  10/09/2012
--	---	--	---

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
	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Furthermore, the K-class fire extinguisher lacked a placard indicating its use is secondary to the overhead hood extinguishing system. This was verified by the maintenance supervisor and hospital safety officer at the time of record review and acknowledged by the director of nursing at the 1:40 p.m. exit conference on 10/09/12.</p> <p>3.1-19(b)</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  10/09/2012	
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			
K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 3 of 4 quarters. This deficient practice affects all residents in the facility including staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports with the maintenance supervisor and hospital director of plant operations on 10/09/12 at 10:00 a.m., the facility used a printed annual schedule for fire drills with a scheduled date for each drill conducted. Furthermore, there was no Fire Drill Report for the scheduled fire drills for the 12/12/11 third shift fire drill at 5:00 a.m., the 03/01/12 third shift fire drill at 11:30 p.m., the 05/17/12 second shift fire drill at 6:30 p.m., or the 06/20/12 third shift fire drill at 1:00 a.m. Additionally, based on an interview during the record review, the maintenance supervisor found no other</p>	K0050	<p>It is the intent of this facility to conduct quarterly fire drills on each shift and complete a fire drill report.. I. Corrective action for affected residents: 1. Environment Supervisor re-educated and re-inserviced on facility policy in regarding requirement to hold fire drills quarterly for each shift and completion of paperwork. Facility continues to participate in Henry County Hospital fire drills as secondary fire drill awareness training. II. Other residents with potential to be affected: 1. No residents were affected. III. Measures to prevent reoccurrence: 1. Administrator/designee to review fire drill report ensuring all shifts are included and timely. IV. Monitoring of corrective action to ensure the practice will not recur: 1. Administrator/designee will review the Fire Drill report in the monthly safety meeting and quarterly in the facility QA meeting. V. Date</p>	11/08/2012			

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  10/09/2012
--	---	--	---

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
	documentation available for review to verify these fire drills were conducted. This was acknowledged by the director of nursing at the 1:40 p.m. exit conference on 10/09/12.  3.1-19(b) 3.1-51(c)		Completed: 11/8/2012	

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  10/09/2012	
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			
K0062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 observation and interview, the facility failed to ensure 5 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 36 residents who use the main dining room and 12 residents who use the therapy room.</p> <p>Findings include:</p> <p>Based on observations on 10/09/12 during a tour of the facility from 11:58 a.m. to 1:40 p.m. with the maintenance supervisor and hospital director of plant operations, the main dining room bathroom, the main dining room by the freezer, resident room # 364, the therapy room closet, and the walk in cooler # 3 each had a missing escutcheon on the sprinklers. Furthermore, the maintenance supervisor's office sprinkler escutcheon was not flush to the ceiling with a one inch gap between the escutcheon and the drop ceiling tile. This was acknowledged by the maintenance supervisor at the time of observations and acknowledged by the director of nursing at the 1:40 p.m. exit conference on 10/09/12.</p>	K0062	<p>It is the intent of this facility to ensure sprinkler heads are maintained. I. Corrective action for affected residents: 1. In regards to the main dining room bathroom, the main dining room by the freezer, resident room #364, the therapy room closet, and the walk in cooler #3, the missing escutcheon have been replaced by Henry County Hospital. II. Other residents with potential to be affected: 1. No residents were affected. III. Measures to prevent reoccurrence: 1. Environment supervisor/designee will do monthly audit as part of the preventative maintenance program of all sprinkler heads to ensure placement of escutcheons. IV. Monitoring of corrective action to ensure the practice will not recur: 1. Administrator/designee will review the audit results in the monthly safety meeting and quarterly in the facility QA meeting. V. Date completed: 11/8/2012</p>	11/08/2012			

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  10/09/2012
--	---	--	---

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
	3.1-19(b)			

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  10/09/2012	
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			
K0064 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguisher in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice affects mainly staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 10/09/12 at 12:15 p.m. with the maintenance supervisor and hospital director of plant operations, the kitchen K-class fire extinguisher, located on the east wall near the cooking surface, lacked a placard indicating the kitchen fire protection system was to be activated prior to using the K-class fire extinguisher. Based on interview on 10/09/12 at 1:00 p.m. with the hospital safety officer, it was acknowledged the K-class portable fire extinguisher lacked a placard. This was verified by the director of nursing at the 1:40 p.m. exit conference on 10/09/12.</p> <p>3.1-19(b)</p>	K0064	<p>It is the intent of this facility to maintain a portable fire extinguisher in the kitchen cooking area. I. Corrective action for affected residents: 1. Henry County Hospital maintenance staff to install a placard indicating the kitchen fire protection system is to be activated prior to using the K-class fire extinguisher. II. Other residents with potential to be affected: 1. No residents were affected. III. Measures to prevent reoccurrence: 1. Environment Supervisor/designee will do monthly audit as part of the preventative maintenance program to ensure placement of placard next to the portable kitchen K-class fire extinguisher. IV. Monitoring of corrective action to ensure the practice will not recur: 1. Administrator/designee will review the audit results in the monthly safety meeting and quarterly in the facility QA meeting. V. Date completed: 11/8/2012</p>	11/08/2012			

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  10/09/2012	
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			
K0147 SS=D	<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 1 electrical outlets near the sink in the nourishment room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(B), Other Than Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens at receptacles intended to serve the counter top surfaces. 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 10/09/12 at 12:10 p.m., the staff nourishment room had an electric receptacle on the wall within two feet of the sink which was not provided with a ground fault circuit interrupter. Furthermore, the main electrical panel serving the area located in</p>	K0147	<p>It is the intent of this facility to ensure electrical outlets near a sink are provided with ground fault circuit interrupter. I. Corrective action for affected residents: 1. In regards to electrical outlet near the sink in the nourishment room, outlet was removed. II. Other residents with potential to be affected: 1. No residents were affected. III. Measures to prevent reoccurrence: 1. Environment Supervisor/designee will do monthly audit as part of the preventative maintenance program of all outlets near sinks to ensure the placement of GFCI protective device. IV. Monitoring of corrective action to ensure the practice will not recur: 1. Administrator/designee will review the audit results in the monthly safety meeting and quarterly in the facility QA meeting. V. Date completed: 11/8/2012</p>	11/08/2012			

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  10/09/2012
--	---	--	---

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
	<p>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 10/09/12 at 12:20 p.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 a the 1:40 p.m. exit conference on 10/09/12.</p> <p>3.1-19(b)</p>			