

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
---	---

(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: 02/15/12</p> <p>Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Scottsburg II, LLC 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 (000) 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. THIS PLAN OF CORRECTION CONSTITUTES OUR CREDIBLE ALLEGATION OF COMPLIANCE WITH REGULATORY REQUIREMENTS. OUR DATE OF COMPLIANCE IS 03/15/2012.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>a capacity of 99 and had a census of 67 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/20/12.</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:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
---	---

(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>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, interview and record review; the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors in the wall separating the kitchen, a hazardous area, from the exit corridor. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any residents using the main dining</p>	K0029	<p>KO29 IT IS THE INTENT OF THIS FACILITY TO ENSURE THE CARE AND MAINTENANCE OF 2 OF 2 ROLLING FIRE DOORS IN THE KITCHEN MEET SET STANDARDS. 1. ACTIONS TAKEN FOR THE RESIDENTS IDENTIFIED: A. THE TWO ROLLING FIRE DOORS IN THE KITCHEN HAVE BEEN INSPECTED AND SERVICED BY LICENSED CONTRACTORS WITH ALL DOCUMENTATIONS TO MEET SET STANDARDS 2. HOW OTHER RESIDENTS WHERE IDENTIFIED: A. THE FACILITY ONLY HAS ONE KITCHEN 3. SYSTEMS IN PLACE: A. THE MAINTENANCE SUPERVISOR/DESIGNEE WILL INSPECT BOTH ROLL UP DOORS AS A PART OF THE FACILITIES MONTHLY PREVENTIVE MAINTENANCE PROGRAM TO MEET SET STANDARDS. 4. MONTITORING A.THE ADMINISTRATOR/DESIGNEE WILL REVIEW ALL INSPECTION RESULTS AT</p>	03/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/15/2012
NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170		
(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>room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 02/15/12 at 11:45 a.m. with the Maintenance Supervisor, there were two rolling fire doors protecting the openings from the kitchen to the main dining room without an attached inspection tag. The main dining room was open to the corridor. Based on interview on 02/14/12 and subsequent Fire Safety record review at 10:00 a.m. with the Maintenance Supervisor and Administrator, it was acknowledged there was no documentation of an annual inspection or test to check for proper operation and full closure of the two kitchen vertical rolling fire doors.</p> <p>3.1-19(b)</p>		<p>QUARTERLY QA COMMITTEE MEETINGS. 5. DATE OF COMPLIANCE: 03/15/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
---	---

(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
--------------------	--	---------------	---	----------------------

K0051 SS=F	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm control panels located in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in</p>	K0051	<p>K051 IT IS THE INTENT OF THIS FACILITY TO ENSURE ALL FIRE ALARM CONTROL PANELS LOCATED IN AN AREA NOT CONTINUOUSLY OCCUPIED IS PROVIDED WITH AUTOMATIC SMOKE DETECTIONS.</p> <p>1. ACTIONS TAKEN: A. THE FACILITY HAD A LICENSED CONTRACTOR INSTALL A SMOKE DETECTION TO MEET SET STANDARDS ELECTRONICALLY SUPERVISED</p> <p>2. HOW OTHER RESIDENTS WHERE IDENTIFIED: A. THE FACILITY ONLY HAS ONE MAIN FIRE ALARM PANEL</p> <p>3. SYSTEMS IN PLACE: A. THE MAINTENANCE SUPERVISOR/DESIGNEE WILL CONDUCT MONTHS INSPECTIONS OF THE MAIN FIRE ALARM PANEL AS A</p>	03/15/2012
---------------	---	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/15/2012
NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170		
(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>that location. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 02/15/12 at 12:15 p.m. during a tour of the facility with the Maintenance Supervisor, the fire alarm control panel and digital phone dialer were located in the emergency generator room and the room was not electrically supervised by a smoke detector. This was verified by the Maintenance Supervisor at the time of observation and confirmed by the administrator at the 1:20 p.m. exit conference on 02/15/12.</p> <p>3-1.19(b)</p>		<p>PART OF THE FACILITIES MONTH'S PREVENTIVE MAINTENANCE PROGRAM TO MEET SET STANDARDS.</p> <p>4. HOW MONITORED: A. THE ADMINISTRATOR/DESIGNEE WILL REVIEW WITH QA COMMITTEE ALL INSPECTION RESULTS AT QUARTERLY Q.A. MEETINGS.</p> <p>5. DATE OF COMPLIANCE: 03/15/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/15/2012	
NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170			
(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
K0144 SS=F	<p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciators was provided with the indication of an alarm condition for the battery charger malfunctioning, low water temperature, excessive water temperature, overcrank, and overspeed. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load.</li> <li>2. When the battery charger is malfunctioning.</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure.</li> <li>2. Low water temperature.</li> <li>3. Excessive water temperature.</li> <li>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating</li> </ol>			K0144	<p>K144 IT IS THE INTENT OF THIS FACILITY TO ENSURE EMERGENCY GENERATOR ANNUNCIATOR IS SET UP TO MEET THE SET STANDARDS</p> <ol style="list-style-type: none"> <li>1. ACTIONS TAKEN: <ol style="list-style-type: none"> <li>A. THE FACILITY HAD A LICENSED CONTRACTOR REPLACE THE ANNUNCIATOR TO MEET SET STANDARDS.</li> </ol> </li> <li>2. HOW OTHER RESIDENTS WHERE IDENTIFIED: <ol style="list-style-type: none"> <li>A. THE FACILITY ONLY HAS ONE GENERATOR</li> </ol> </li> <li>3. SYSTEMS IN PLACE: <ol style="list-style-type: none"> <li>A. THE MAINTENANCE SUPERVISOR/DESIGNEE WILL INSPECT THE GENERATORS ANNUNCIATOR AS A PART OF FACILITIES MONTHLY PREVENTIVE MAINTENANCE PROGRAM TO MEET SET STANDARDS.</li> </ol> </li> <li>4. HOW MONITORED: <ol style="list-style-type: none"> <li>A. RESULTS OF THE MONTHLY INSPECTIONS WILL BE REVIEWED BY THE ADMINISTRATOR AND QA COMMITTEE DURING QUARTERLY QA MEETINGS.</li> </ol> </li> <li>5. DATE OF COMPLIANCE 03/15/2012</li> </ol>		03/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  02/15/2012	
NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>supply.</p> <p>5. Overcrank (failed to start).</p> <p>6. Overspeed.</p> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/15/12 at 12:30 p.m. with the Maintenance Supervisor, the remote alarm annunciator for the generator which was located at the central nurses' station was only provided with a visual and audible alarm signal for Generator Run and Low Oil.</p> <p>The remote alarm annunciator lacked the indication of an alarm condition for the battery charger malfunctioning, low water temperature, excessive water temperature, overcrank, and overspeed. Furthermore, based on observation of the emergency generator with the Maintenance Supervisor on 02/15/12 at 12:45 p.m., there were no electrical connections from the emergency generator to the remote</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WATERS OF SCOTTSBURG II LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
---	---

(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
--------------------	--	---------------	---	----------------------

	annunciator for the battery charger, low water temperature, excessive water temperature, overcrank and overspeed. This was verified by the Maintenance Supervisor at the time of observation and acknowledged by the Administrator at the 02/15/12 exit conference at 1:10 p.m.  3.1-19(b)			
--	--	--	--	--