

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 04/16/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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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: 04/16/13</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 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 battery operated smoke detectors in all resident sleeping rooms. The facility</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 conclusion 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.	

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>has a capacity of 99 and had a census of 68 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a detached wooden shed, a detached twelve foot by ten foot metal smoking building, and a detached twenty foot by thirty foot metal storage building.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/18/13.</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=F	<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 observations and interview, the facility failed to ensure 5 of 5 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 04/16/13 during observations of the attic smoke barriers above the smoke barrier doors from 12:40 p.m. to 1:00 p.m., the following attic smoke barrier walls above smoke barrier doors had penetrations with no fire stopping material:</p> <p>a. The Sapphire Hall smoke barrier wall had three, two inch diameter areas around a cable bundle, electrical conduit, and an open electrical conduit with no firestopping.</p> <p>b. The Dining Hall smoke barrier wall</p>	K010025	<p>K025 It is the intent of this facility to provide protection to residents by ensuring smoke barriers are constructed to provide at least a one half hour fire resistance rating.1. Actions taken: A. 100 percent audit conducted on all halls to see if any other areas affectd.2. Others identified: no other issues identified.3. Measures taken: A. All halls with smoke barrier areas that were opened were fixed with fire barrier sealant CP 25WBT.4. How monitored: A. Maintenance will inspect halls monthly to ensure smoke barrier areas are in compliance. B. This issue will be discussed at quarterly QA meetings.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is May 8, 2013.</p>	05/08/2013			

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	<p>had four, one inch to three inch diameter areas around water piping, cable bundles, and an open electrical conduit with no firestopping.</p> <p>c. The Emerald Brook Hall smoke barrier wall had five, one inch to three inch diameter areas around water piping, and an open electrical conduit with no firestopping.</p> <p>d. The Onyx Hall smoke barrier wall had a six inch by six inch area around a cable bundle with no fire stopping material.</p> <p>e. The Administration Hall smoke barrier wall had two, two inch areas around a cable bundle and sprinkler pipe with no firestopping material.</p> <p>This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 04/16/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>				

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K010029 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 12 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 24 residents who reside on the Onyx Cove Hall.</p> <p>Findings include:</p> <p>Based on observations on 04/16/13 during a tour of the Onyx Cove Hall from 11:15 a.m. to 11:40 a.m. with the maintenance supervisor, the one hundred and forty four square foot supply room and the one hundred forty four square foot housekeeping supply room which stored combustibile cardboard boxes of paper towels and toilet paper lacked self closing</p>	K010029	<p>K 0029 It is the intent of this facility for all areas that store or protect hazardous materials be protected by doors with self closing plates.1. Action taken: A. 100 percent audit on all doors that require self closing plates was completed.2. Others identified: No other areas identified.3. Measures taken: A. The two doors in question were adjusted to ensure that doors would shut properly each time used.4. How monitored: A. Maintenance will audit the two doors in question weekly to ensure proper closure. B. This issue will be discussed in quarterly QA meetings.5. This plan of correction constitutes our credible allegation of compliance with all regualtory requirements. Our date of compliance is May 8, 2013.</p>	05/08/2013

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	<p>devices on the doors to the rooms. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 04/16/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>			

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K010062 SS=F	<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 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents in the facility in the event of a fire and the fire hydrant needed to be utilized.</p> <p>Findings include:</p> <p>Based on observation on 04/16/13 at 12:10 p.m. with the maintenance supervisor, the facility had one fire hydrant located in the west side parking lot. Based on an interview with the administrator on 04/16/13 at 1:00 p.m., the fire hydrant is owned by the facility and there are no records available to indicate an annual inspection was</p>	K010062	F 062 It is the intent of this facility to ensure sprinkler systems are maintained in reliable operating condition.1. Actions taken: A. Immediately called JA fire protection to test the hydrants in question.2. Others identified: No other issues identified.3. Measures taken: A. JA fire protection did inspection, tested and maintenance on hydrants in question.4. How monitored: A. All fire hydrant records are in red book. Fire hydrants inspected once a year or after use. 5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is May 8, 2013.	05/08/2013			

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	<p>conducted on the fire hydrant. This was confirmed by the administrator at the exit conference on 04/16/13 at 1:15 p.m.</p> <p>3.1-19(b)</p>			