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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 09/07/2012 |
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| NAME OF PROVIDER OR SUPPLIER WATERS OF DUNELAND THE | STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304 |
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| (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 Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 09/07/12</p> <p>Facility Number: 000150 Provider Number: 155246 AIM Number: 100267700</p> <p>Surveyor: Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Quality Assurance Walk-thru survey, The Waters of Duneland was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, and areas open to the corridors with battery operated smoke detectors in the resident rooms. The facility has a capacity of 100 and had a census of 89 at the time of this visit.</p> <p>The facility was found not in compliance with state law in regard to sprinkler coverage and in compliance with state law with smoke detector coverage.</p> | K0000 | | |

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 areas where residents have customary access were sprinklered, except an exterior wooden 16 by 12 foot totally enclosed shed with a door being used for resident smoking as well as employee smoking. All areas providing facility services were sprinklered except two detached wooden sheds providing facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/24/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

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| K9999 | <p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to provide sprinkler protection in all combustible structures residents use. This deficient practice could affect 6 of 89 residents.</p> <p>Findings include:</p> <p>Based on observation with the Chief</p> | K9999 | <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 or federal laws. This Plan of Correction constitutes our credible allegation of compliance with regulatory requirements.</p> <p>The double doors on the smoking building have been removed. This has created an opening 6'5" high by 5'11" wide, so that the building is no longer totally enclosed. Other residents having the potential to be affected by the alleged deficient practice would be identified per a smoking assessment, done at the time of admission to the facility. No other residents have been identified at this time. Measures put into place to ensure the alleged deficient practice does not reoccur are; doors to the building, along with their hinges have been removed. Maintenance Director and Administrator will monitor this corrective action to ensure that the double doors to the smoking building will not be reinstalled.</p> | 09/25/2012 | | | |

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| | <p>Executive Officer on 09/07/12 at 9.00 a.m., the resident smoking building, a separate totally enclosed, detached building of Type V (000) construction lacked sprinkler protection. Based on interview at the time of observation, the Chief Executive Officer acknowledged there are 6 residents who smoke and use the nonsprinklered smoking building.</p> <p>3.1-19(b) 3.1-19(ff)</p> | | | |