

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  07/17/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
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K020000	<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: 07/16/14 and 07/17/14</p> <p>Facility Number: 000178 Provider Number: 155280 AIM Number: 100273840</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Dillsboro-Ross Manor 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 and 410 IAC 16.2. The original Waters of Dillsboro building and Ross Manor buildings were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The Waters of Dillsboro-Ross Manor consisted of two separate buildings. The Waters of Dillsboro, a two story facility was determined to be of Type II (000)</p>	K020000	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 law. This plan of correction constitutes our credible allegation of compliance with regulatory requirements. Our date of compliance is August 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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K020012 SS=E	<p>construction with a basement and fully sprinkled. Ross Manor, a one story facility was determined to be Type V (111) construction and fully sprinkled. Both buildings have a fire alarm system with smoke detection on all levels of the Waters of Dillsboro building and Ross Manor building including the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The Waters of Dillsboro-Ross Manor has a capacity of 123 and had a census of 100 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/22/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3,</p>				

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	<p>19.1.6.4, 19.3.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 floors was constructed with a 1 hour rated floor structure. This deficient practice affects 67 residents who reside in the Waters of Dillsboro building.</p> <p>Findings include:</p> <p>Based on a tour of the Waters of Dillsboro building basement on 07/17/14 from 8:20 a.m. to 10:45 a.m. with the maintenance supervisor, the basement to first floor was separated with exposed wood floor joists throughout the entire basement with no interior finish covering the wooden floor joists. The basement was used as a maintenance workshop, storage location, and laundry. Based on an interview with the maintenance supervisor on 07/17/14 at 9:00 a.m., the first floor is constructed of one half inch plywood with vinyl flooring throughout the first floor with no fire rated material. Furthermore, based on a tour of the first floor with the maintenance supervisor from 10:50 a.m. to 12:20 p.m. on 07/17/14, the first floor air handler room ceiling had a six inch sprinkler pipe penetration to the second floor with a one inch gap around the ceiling sprinkler pipe penetration and the first floor food storage locker room ceiling was</p>	K020012	<p>Please see attachment labeled K 012 (8 pages) Fire safety evaluation system (FSES), plus the Life Safety Code Waiver request letter (2 pages). Based on the passing scores achieved in the FSES form, We are of the understanding tht this facility will be provided the level of fire safety at least equivalent to that prescribed by the Life Safety Code. It is the intent of this facility to meet the life safety code standards as required. A. ACTION TAKEN: FP&amp;C consultants, Inc. were retained to evaluate the building through the Fire Safety Evaluation System (FSES). B. OTHERS IDENTIFIED: None C. MEASURES TAKEN: No further recommendations. D. HOW MONITORED: 1.The maintenance supervisor/designee will continue to monitor life safety code in the facility as required by regulations. 2. Any changes to the structure of the building will be reported to life safety for review to stay with-in the required standards of the building. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014. It is the intent of this facility to ensure that the first floor food storate locker room ceiling will be covered with a fire resistance rating. A. ACTION TAKEN: The ceiling in the firt floor</p>	08/15/2014			

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	<p>constructed of one quarter inch wood paneling. Based on an interview with the maintenance supervisor on 07/17/14 at 12:20 p.m., the food storage locker room wood paneled ceiling does not have a fire resistance rating. The basement ceiling lacking one hour construction, the first floor air handler room sprinkler pipe penetration not being fire stopped, and the first floor food storage locker room ceiling covered with non rated wood paneling was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/17/14 at 3:30 p.m.</p> <p>3.1-19(b)</p>		<p>food storage locker room will be covered with 5/8" drywall to meet the requirements of a fire resistant rating. B. OTHERS IDENTIFIED: No other areas identified. C. MEASURES TAKEN: The maintenance supervisor/designee will inspect all applicable ceilings to ensure that requirements of a fire resistant rating is maintained as part of the facility's monthly maintenance program. D.HOW MONITORED: 1. Any inconsistant results will be immediately corrected appropriately. 2. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014. It is the intent of this facility to ensure that all sprinkler pipe penetrations to the second floor are fire stopped. A. ACTION TAKEN: In the Dillsboro building, the first floor air handler room ceiling 6" sprinkler pipe penetration to the second floor with a 1" gap around the ceiling sprinkler pipes was fire caulked. B. OTHERS IDENTIFIED: 100% audit of all sprinkler pipes in the Dillsboro building with no other issues found. C. MEASURES TAKEN: The maintenance supervisor/designee will inspect all sprinkler pipes in the Dillsboro</p>	

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K020018 SS=A	<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 1 of 3 kitchen corridor doors in the Waters of Dillsboro building was provided with a means suitable for keeping the door closed and capable of resisting the passage of smoke. This deficient practice affects kitchen</p>	K020018	<p>building as part of the facility's monthly maintenance program. D. HOW MONITORED: Any inconsistent results will be immediately corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA meetings for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014.</p> <p>It is the intent of this facility to ensure kitchen corridor doors in the Dillsboro building are provided with a means for keeping the door closed and capable of resisting the passage of smoke. A. ACTION TAKEN: 1.Latching hardware was put on kitchen</p>	08/15/2014	

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K020025 SS=E	<p>staff and no residents.</p> <p>Findings include:</p> <p>Based on observation on 07/17/14 at 10:50 a.m., the kitchen food storage room door had a one inch gap along the top and latching side of the door. Furthermore, the kitchen food storage room door was not provided with latching hardware. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/17/14 at 3:30 p.m.</p> <p>3.1-19(b)</p> <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>corridor door. 2. New smoke resisting strip was placed on kitchen corridor door . B. OTHERS IDENTIFIED: 100% audit of kitchen doors for appropriate hardware and smoke resisting strips with no others identified. C. MEASURES TAKEN: The maintenance supervisor/designee will inspect all kitchen doors for hardware for keeping doors closed and smoke resistant strips as part of the facility's monthly maintenance checks. D. HOW MONITORED: 1. Any inconsistant results will be immediately corrected appropriately. 2. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014.</p>	
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K020046 SS=E	<p>Based on observation and interview, the facility failed to ensure 1 of 7 first floor attic smoke barrier walls in the Waters of Dillsboro building was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 43 residents who reside on the first floor Unit Hall and Short Hall in the Waters of Dillsboro building.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 07/17/14 at 2:30 p.m., the Waters of Dillsboro building first floor attic smoke barrier wall between the Unit Hall and Short Hall had two, three inch circular areas of drywall missing in the center of the smoke barrier wall.</p> <p>This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/17/14 at 3:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p>	K020025	<p>It is the intent of this facility to ensure the Dillsboro building first floor attic smoke barrier wall between the Unit Hall and Short hall are constructed to provide fire resistance ratings to meet set standards. A. ACTIONS TAKEN: The two, three inch circular areas of drywall missing in the center of the smoke barrier wall were fire caulked. B. OTHER RESIDENTS IDENTIFIED: Maintenance completed a 100% audit on the Dillsboro building attic smoke barrier walls with no other areas identified. C. MEASURES TAKEN: The maintenance supervisor/designee will inspect all attic smoke barrier walls as part of the facility's monthly preventative maintenance program. D. HOW MONITORED: 1. Any inconsistent results will be immediately corrected appropriately 2. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014.</p>	08/15/2014			
	<p>Based on observation and interview, the facility failed to ensure 1 of 10 exits in</p>	K020046	<p>It is the intent of this facility to ensure the building is provided</p>	08/15/2014			

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K020071 SS=E	<p>the Waters of Dillsboro building was provided with emergency powered exterior lighting. This deficient practice affect 12 residents,who reside on the second floor Short Hall in the Waters of Dillsboro building.</p> <p>Findings include:</p> <p>Based on observation on 07/17/14 at 1:50 p.m. with the maintenance supervisor, the second floor Short Hall exit in the Waters of Dillsboro building by the old elevator was not provided with emergency lighting outside the exit door. Based on an interview with the maintenance supervisor on 07/17/14 at 1:55 p.m., the exit had a battery backup outside light, but the battery pack went dead and the light was taken down. The lack of outside emergency lighting at the second floor Short Hall exit was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/17/14 at 3:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes:</p>		<p>with emergency powered exterior lighting. A. ACTION TAKEN: An emergency light outside the exit door on the second floor short hall was installed. B. OTHER RESIDENTS AFFECTED: 100% audit on all emergency lighting outside exit doors. No other areas identified. C. MEASURES TAKEN: Maintenance/designee will monitor emergency lighting outside exit doors as part as the facility's monthly maintenance program. D. HOW MONITORED: 1. Any inconsistant result will be immediately corrected appropriately. 2. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014.</p>		

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	<p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 laundry chutes in the Waters of Dillsboro building was provided with a smoke resistant door. LSC 8.2.3.2.3.1 requires every opening shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice affects 14 residents who reside on the first floor Short Hall in the Waters of Dillsboro building.</p> <p>Findings include:</p> <p>Based on observation on 07/17/14 at</p>	K020071	<p>It is the intent of this facility to ensure that laundry chutes are provided with smoke resistant doors. A. ACTION TAKEN: The laundry chute in the Dillsboro building on the first floor short hall had the door seal replaced. B. OTHERS IDENTIFIED: 100% of all laundry chutes in the Dillsboro building were audited and no other issues were identified. C. MEASURES TAKEN: Maintenance/designee will monitor all laundry chutes as part of facility's monthly maintenance program. D. HOW MONITORED: 1. Any inconsistent results will be immediately corrected appropriately. 2. Results will be monitored and</p>	08/15/2014

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K020143 SS=E	<p>11:45 a.m. with the maintenance supervisor, the first floor Short Hall laundry chute door had a one inch gap around the door seal with the door in the closed position. Based on an interview with the maintenance supervisor on 07/17/14 at 11:50 a.m., the door seal is rotted and not making a smoke tight seal. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/17/14 at 3:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen</p>	K020143	<p>reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014.</p> <p>It is the intent of this facility to ensure that the oxygen storage/transfer location in the</p>	08/15/2014

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	<p>storage/transfer locations in the Ross Manor building was provided with a 1 hour fire resistant ceiling. This deficient practice could affect 10 residents who reside on North Hall in rooms 11, 12, 13, 14, and 15 located near the liquid oxygen room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 07/16/14 at 1:50 p.m., the Ross Manor building liquid oxygen storage room, where five full liquid oxygen containers were stored, had a ceiling consisting of metal soffit material nailed to wooden ceiling studs. Based on an interview with the maintenance supervisor on 07/16/14 at 2:00 p.m., the metal ceiling soffit material does not have a fire resistance rating and the nursing staff uses the liquid oxygen room for a transfilling location for small portable oxygen containers for resident use. The lack of a one hour rated ceiling in the liquid oxygen storage room in the Ross Manor North Hall was verified by the maintenance supervisor at the time of observation and interview and acknowledged by the administrator at the exit conference on 07/17/14 at 3:30 p.m.</p> <p>3.1-19(b)</p>		<p>Ross building is provided with a one hour fire resistant ceiling. A. ACTION TAKEN: ?????? B. OTHERS IDENTIFIED: This is the only oxygen storage/transfer location in the Ross building. No others identified. C. MEASURES TAKEN: Maintenance supervisor/designee will monitor the oxygen storage/transfer location for compliance with one hour fire resistant ceilings as part of the facility's monthly maintenance program. D: HOW MONITORED: 1. Any inconsistent results will be immediately corrected appropriately. 2. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August 15, 2014.</p>	

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K020147 SS=E	<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 4 of 67 wet location resident care areas were 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 affect 14 residents who reside on the first floor Short Hall and 28 residents who reside on the Reflections Hall in the Waters of Dillsboro building along with kitchen staff and medical records and nursing staff.</p>	K020147	<p>It is the intent of this facility to ensure that all receptacles and fixed equipment within the area of a wet location, have a ground-fault circuit interrupter (GFCI). A. ACTION TAKEN: 1. In the Dillsboro building, short hall first floor linen room and medical office, electrical outlet was removed. 2. The kitchen receptacle ws placed on a GFCI. 3. The Reflections Hall soiled linen room eletrical outlet was placed on a GFCI breaker. B. OTHERS IDENTIFIED: 100% audit of all receptacles without GFCI's were identified. C. MEASURES TAKEN: Maintenance supervisor/designee will monitor all electrical outlets to ensure they are on GFCI as appropriate during facility's monthly maintenance program. D. HOW MONITORED: 1. Any inconsistant results will be imediately corrected appropriately. 2. Results will be monitored and reviewed at the monthly and quarterly QA meeting for determination of ongoing monitoring. E. This plan of correction consitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is August</p>	08/15/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280		X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____		X3) DATE SURVEY COMPLETED  07/17/2014	
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
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K030000	<p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 07/17/14 during a tour of the Waters of Dillsboro building from 8:40 a.m. to 3:30 p.m., the kitchen, Short Hall first floor soiled linen room, medical records office bathroom, and Reflections Hall soiled linen room each had an electrical outlet within two feet of a handwash basin with no ground fault circuit interrupters on the electric outlets. Based on observation of the main electrical breaker panels with the maintenance supervisor at the time of observations, the circuit breakers for the electric outlets were not provided with GFCI protection. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/17/14 at 3:30 p.m.</p> <p>3.1-19(b)</p> <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: 07/16/14 and 07/17/14</p>	K030000	<p>15, 2014.</p> <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</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED  07/17/2014	
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018			
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	<p>Facility Number: 000178 Provider Number: 155280 AIM Number: 100273840</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Dillsboro-Ross Manor 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 and 410 IAC 16.2. The 2010 Therapy Wing addition, located to the south of the original Ross Manor building consisting of a single room used for therapy with a two hour separation from the original building, was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2010 Therapy Wing addition to the one story Ross Manor building was determined to be Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection 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 123 and had a census of 100</p>		<p>plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal law. This plan of correction constitutes our credible allegation of compliance with regulatory requirements. Our date of compliance is August 15, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED  07/17/2014
NAME OF PROVIDER OR SUPPLIER  WATERS OF DILLSBORO-ROSS MANOR THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018		
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	at the time of this visit.  All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.				