

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155202	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF GREENCASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 HOSPITAL DR GREENCASTLE, IN 46135
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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: 08/28/13</p> <p>Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Waters of Greencastle 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has battery operated smoke detectors in all resident</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 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.	

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>sleeping rooms. The facility has a capacity of 100 and had a census of 81 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. Three detached equipment storage sheds were unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/04/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 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 doors protecting corridor openings in 1 of 8 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 20 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/13 at 1:15 p.m., double doors provided access to the physical therapy department. One inactive (no door knob) door was equipped with a manual flush bolt. In order to secure the doors in the door frame, the flush bolt had to be engaged</p>	K010018	<p>It is the intent of this facility to ensure that all doors are provided with a means suitable for keeping the door closed.1. Action Taken: a. Two door closures, one door coordinator and door knob were installed to meet set standards.How Other Residents were Identified: a. All doors were inspected\tested to meet set standards.Systems in Place: a. The Maintenance Director\Designee will inspect\audit all doors as a part of the monthly preventative maintenance program to ensure proper closure. Monitoring: a. Inspection\audit results will be reviewed by the Administrator\Designee monthly during the monthly QA meeting and quarterly in the QA meeting with the Medical Director.</p>	09/19/2013			

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	and then the second door latched into the inactive door. The maintenance director acknowledged at the time of observations, each door could not latch independently into the door frame. 3.1-19(b)				

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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>1. Based on observation and interview, the facility failed to ensure 1 of 10 doors to hazardous areas, such as a storage room for the collection of soiled linens, trash, and dedicated hazardous waste containers would latch. Doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 20 or more residents on the Moonlight Bay wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/13 at 12:20 p.m., the self closing corridor door to the Moonlight Bay soiled utility room was not latched. The door could be pushed open without turning the door knob. Upon closer inspection by the</p>	K010029	<p>It is the intent of this facility for doors to latch in the door frame when closed to keep the door tightly closed and for doors to hazardous areas be closed automatically.1. Action Taken: a) Removed tape from Moonlight Bay Utility Room door for latch to engage. b) Automatic door closures installed to Activity Storage Room and Central Supply Storage Room 2. How other residents were identified: a)100 % audit completed on doors with no other findings. 3. Systems in Place: a) Inservice of staff on appropriate door closure. b) The Maintenance Director\Designee will complete a monthly audit on all doors as a part of the monthly preventative maintenance program and any issues will be immediately addressed.. 4. Monitoring: a) The monthly audit will be reviewed by the Administrator\Designee during</p>	09/19/2013

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	<p>maintenance director at the time of observation, the latch had been taped with medical grade plastic tape to hold it, in so it could not engage into the latch stile to secure the door tightly into the door frame. The maintenance director said at the time of observation, the door should have latched.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 10 doors to hazardous areas, such as combustible materials storage rooms larger than 50 square feet, closed automatically or upon activation of the fire alarm system. This deficient practice affects visitors, staff and 20 or more residents in the center smoke compartment and Moonlight Bay wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/13 between 11:45 a.m. and 12:10 p.m., the door to the 64 square foot activities storage room and the door to the 80 square foot central supply storage room each had no means to self or automatically close into the door frame. The rooms were filled with cardboard, paper, plastic and fabric combustibles.</p>		<p>the Monthly QA meeting and quarterly in the QA meeting with the Medical Director.</p>				

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	The maintenance director said at the time of observation, the rooms had just been repurposed. 3.1-19(b)			

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K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>1. Based on observation and interview, the facility failed to provide distinctive annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/13 at 1:40</p>	K010051	<p>It is the intent of this facility to provide distinct annunciation for the fire alarm system and an automatic smoke detector at the location of each fire alarm control unit that is not continuously occupied. 1. Action Taken: a) New Annuciator panel installed inside active Moonlight Bay nurses station. b) Smoke detector placed inside corridor within inactive Moonlight Bay nurses station. c) Assured that smoke detecor in active Moonlight Bay nurses station is appropriately working. d) Inservice staff on acknowledgement of trouble signal 2. How other residents were identified: a) All fire alarm</p>	09/19/2013

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	<p>p.m., an adjunct fire alarm control panel (FACP) was located on a corridor wall where a nurses' station had formerly been located. The panel was visible from a new nurses' station which was enclosed with windows and a door, if the occupants stood up and leaned over their desk to look at the panel. The detail of trouble would not be visible from that location. The FACP was put into "trouble" by the maintenance director at 1:45 p.m. with the nurses' station door closed to test the audible feature of the panel. The trouble signal could be heard and nurse # 1 and # 2 acknowledged they could hear the signal although they ignored it until asked what it was. Both nurses said the signal belonged to a resident's personal (safety) alarm. The maintenance director acknowledged at the time of testing, the trouble signal should have been identifiable to nurses on duty.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 fire alarm panels (FACP) in an area not continuously occupied, was provided with automatic smoke detection to ensure notification of a fire at the location before it could be incapacitated by fire. NFPA 72, 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not</p>		<p>panels audited to meet set standards. 3. Systems in Place: a) The Maintenance Director\Designee will complete monthly inspection\audit of fire alarm panel and smoke detectors to meet set standards as a part of the monthly preventative maintenance program, any issues identified will be immediately addressed. 4. Monitoring: a) Inspection\audit will be reviewed by Administrator\Designee in monthly QA meeting and reviewed with Medical Director in quarterly QA meeting.</p>				

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	<p>located in an area continuously occupied to provide notification of a fire in that location. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/13 at 1:45 p.m., an adjunct fire alarm control panel (FACP) was located in the corridor at the site of a former Moonlight Bay nurses' station. The area was no longer continuously occupied. The area was not electrically supervised by a smoke detector. The nearest smoke detector was located around a corner near a smoke barrier door 10 to 12 feet from the FACP location. The maintenance director acknowledged the location of the nearest smoke detector at the time of observation.</p> <p>3.1-19(b)</p>				

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 cylinders of nonflammable gases in the oxygen supply storage room was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 20 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/13 at 1:00 p.m., one oxygen cylinder was standing on a shelf without support in the oxygen supply storage room with three liquid oxygen containers and three oxygen</p>	K010076	<p>It is the intent of this facility to ensure that cylinders of nonflammable gases in the oxygen supply storage room be properly stored; chained or supported in a cylinder stand or cart. 1. Action Taken: a) Cylinder of nonflammable gases in the oxygen supply room has been properly stored in a cylinder stand\cart. b) Inservice of staff on proper oxygen storage. 2. How other residents were identified: a) The facility only has one oxygen storage room. 3. Systems in Place: a) Maintenance Director\Designee will audit\inspect oxygen room three times per week for 30 days, 1 time a week for 60 days and monthly thereafter to assure oxygen is stored at set standards and any issues will be immediately addressed. 4. Monitoring: a) Administrator\Designee will review audit\inspection during monthly QA meeting and the</p>	09/19/2013			

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	supply cylinders. The maintenance director said at the time of observation, the cylinder should not have been left in this manner and an outside agency was responsible for leaving it there. 3.1-19(b)		Medical Director will review during the quarterly QA meeting.		

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K010144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 alarm annunciators would alert staff to generator alarm conditions. 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"> 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. <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"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 	K010144	<p>It is the intent of this facility to ensure the emergency generator alarms annunciator will alert staff to generator alarm conditions. 1. Actions Taken: a) Audible trouble alarm switch is in "on" position. b) Inservice of staff on generator audible trouble alarm. 2. How other residents were identified: a) The facility only has one emergency generator alarm annunciator - no other findings. 3. Systems in Place: a) Maintenance Director\Designee will audit emergency generator alarm annunciator 5 times per week for 30 days, 3 times per week for 30 days, 1 time per week for 30 days and monthly thereafter to meet set standards as a part of the monthly preventative maintenance program. 4. Monitoring: a) Administrator\Designee will review audit\inspection in monthly QA meeting and quarterly QA meeting with the Medical Director.</p>	09/19/2013			

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	<p>5. Overcrank (failed to start). 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 occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/28/13 at 1:25 p.m., an ancillary remote alarm annunciator for the emergency generator was provided across the corridor from the Moonlight Bay nurses' station. The panel had an audible trouble alarm switch which was in the "off" position. The maintenance director acknowledged the audible trouble alarm would not sound in the "off" position.</p> <p>3.1-19(b)</p>				