

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  10/19/2015
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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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K 0000  Bldg. 01	<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: 10/19/15</p> <p>Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290</p> <p>At this Life Safety Code survey, 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 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, spaces open to the corridors and battery detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 82 at the time of this survey.</p>	K 0000	Preparations and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of 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. The facility respectfully requests paper compliance for this citation.	
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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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K 0029 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached equipment storage sheds which were not sprinklered.</p> <p>Quality Review completed on 10/23/15 - DA</p> <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 2 of 2 doors to hazardous areas such as the kitchen would self close into its frame and resist the passage of smoke. This deficiency could affect 7 residents observed in the Main dining room which is adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p>	K 0029	<p>It is the intent of this facility to ensure that doors to hazardous areas such as the kitchen self close into its frame and resist the passage of smoke. Corrective Actions: 1. Door closures and door holders connected to the fire panel to allow doors to close automatically and latch in the event of a fire\emergency were installed on both doors mentioned. 2. Maintenance Director educated on self-closing doors and devices. Others</p>	11/05/2015

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K 0046 SS=C Bldg. 01	<p>Based on observations on 10/19/15 at 1:15 p.m. with the Maintenance Supervisor, the two corridor doors which separate the kitchen from Main hall were equipped with a self closing devices, but the self closing devices were disabled by pulling the pin which connects the swinging arm to the compression part of the unit. Based on interview on 10/19/15 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned kitchen doors would not self close and latch into its frame without complete assembly of the unit.</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. Based on record review and interview, the facility failed to provide documentation of a 30 second monthly functional test or a 90 minute annual functional test for 1 of 1 battery operated lights. NFPA 110, 5-3-1 requires lighting at the emergency generator. LSC Section 7.9.3 requires a functional test be conducted monthly for 30 seconds on</p>	K 0046	<p>Identified:1. No others findings identified Systems in Place:1. Staff educated on self-closing doors and devices. Monitoring:1. Maintenance Director\designee will monitor self-closing door(s) and devices 3 times a week for 12 weeks, 2 times a week for 8 weeks, and 1 time a week for 4 weeks. Random monitoring will occur ongoing. 2. Administrator\Designee will review all audits\proficiency's as completed daily in QA stand up meeting. Any issues will be immediately addressed and corrected. 3. Results\issues identified will be discussed with the IDT at monthly QA meetings and with the Medical Director at the Quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting.</p> <p>It is the intent of this facility to provide 30 sec\90 min monthly\annual function test on emergency lighting. Corrective action: 1. Implementation of a new 30 sec monthly functional test and 90 minute annual functional test form to be completed by Maintenance Director\Designee. 2. Maintenance Director educated</p>	11/05/2015

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K 0050 SS=C Bldg. 01	<p>every required emergency lighting system and annually for not less than 1 1/2 hours. This deficient practice could affect all occupants in the facility including staff, visitors and residents if emergency battery powered lights were not available.</p> <p>Findings include:</p> <p>Based on Fire Safety Record review on 10/19/15 at 4:08 p.m. with the Maintenance Supervisor the facility tested the battery back up emergency lights located outside adjacent to the generator, but did not document a thirty second monthly test or a ninety minute annual test. Based on interview on 10/19/15 at 4:10 p.m. with the Maintenance Supervisor it was acknowledged the battery back up emergency light was checked monthly, but the documentation for the duration of the monthly and annual test was not documented.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly</p>		<p>on 30 sec\90 min functional test. Others Identified: 1. No additional findings. Systems in Place: 1. Maintenance Director will ensure that 30 sec monthly functional test and 90 minute annual functional test be performed and recorded on appropriate form. Monitoring: 1. Administrator\Designee will review all audits\proficiency's as completed daily in QA stand up meeting. Any issues will be immediately addressed and corrected. 2. Results\issues identified will be discussed with the IDT at monthly QA meetings and with the Medical Director at the Quarterly QA meeting and\or as needed for determination for ongoing monitoring and\or changes to the QA meeting.</p>	

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	<p>on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills on all shifts for 1 of 4 quarters for the past 12 months. This deficient practice affects all residents in the facility including staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill records on 10/19/15 at 3:35 p.m. with the Maintenance Supervisor, a fire drill report for the third shift of the third quarter of 2015 were not available for review. Based on interview on 10/19/15 at 3:37 p.m. with the Maintenance Supervisor, it was acknowledged the fire drill for the third shift of the third quarter of 2015 had not been done.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>It is the intent of this facility to have fire drills held at unexpected times under varying conditions, at least quarterly on each shift. Corrective Actions: 1. An additional 3rd shift fire drill will be completed in the 4th quarter. 2. Fire drills will be completed on each shift quarterly at unexpected times under varying conditions by the Maintenance Director\Designee. Others Identified: 1. No additional findings. Systems in Place: 1. Maintenance Director\Designee will document fire drills and ensure that they are conducted on all shifts at unexpected times under varying conditions. How Monitored: 1. Administrator\Designee will review all audits\proficiency's as completed in QA meeting. Any issues identified will be immediately addressed and corrected. 2. Results\Issues identified will be discussed with the IDT at monthly QA meetings and with the Medical Director at the Quarterly QA meeting and/or as needed for the determination for ongoing monitoring and/or changes to the QA meeting.</p>	11/05/2015

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K 0053 SS=F Bldg. 01	<p>NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7)</p> <p>Based on record review, and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 100 of 100 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2015 documentation with the Maintenance Supervisor during record review at 2:45 p.m. on 10/19/15, all battery powered smoke detectors in all resident rooms for July, August and September of 2015 were not available for review. Based on interview at the time of record review with the the Maintenance Supervisor it was acknowledged the battery powered smoke detectors</p>	K 0053	<p>It is the intent of this facility to provide proper oversight for testing, maintenance, and battery replacement for single station battery-operated smoke detectors. Corrective Actions: 1. All battery powered smoke detectors have been tested and documented on and will be done each month and recorded on the Battery-operated smoke detector maintenance log. Others Identified: 1. No additional findings. Systems in Place: 1. Monthly battery operated smoke detector maintenance checks on all battery powered smoke detectors in all resident rooms by Maintenance Director/designee. Monitoring: 1. Administrator/Designee will review log as completed in QA meeting. Any issues will be immediately addressed and corrected. 2. Results/issues identified will be discussed with the IDT at monthly QA meetings and with the Medical Director at teh Quarterly QA meeting and/or as needed for determination for ongoing monitoring</p>	11/05/2015
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K 0056 SS=E Bldg. 01	<p>installed in all resident rooms had not been tested and maintained for the aforementioned months of 2015.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads in the laundry room was not positioned next to an obstruction which would interfere with the spray pattern of the sprinkler head from fully developing. This deficient practice could affect 24 residents on south 200 hall as well as visitors and staff.</p> <p>Findings include:</p>	K 0056	<p>and/or changes to the QA meeting.</p> <p>It is the intent of the facility to ensure that the automatic sprinkler system, is installed in accordance with NFPA 13, Standard for the installation of sprinkler systems, to provide complete coverage for all portions of the building. Corrective Actions: 1. Sprinkler head was replaced with a new head that is positioned correctly and will provide complete coverage. Others Identified: 1. No additional findings. Systems in Place: 1. Maintenance Director\Designee will inspect all</p>	11/05/2015

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K 0144 SS=F Bldg. 01	<p>Based on observation on 10/19/15 at 2:48 p.m. with the Maintenance Supervisor, the sprinkler head located in the ceiling of the laundry room on south 200 hall was positioned above the ceiling drywall. Based on interview on 10/19/15 at 2:50 p.m. with the Maintenance Supervisor it was acknowledged the ceiling drywall had dropped below the sprinkler head and would interfere with the sprinkler heads spray pattern.</p> <p>3.1-19(b)</p> <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. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of</p>	K 0144	<p>rooms to ensure that there is complete coverage for all portions fo the building as part of the monthly preventative maintenance program. Monitoring:1. Administrator/Designee will review preventative maintenance program in QA meeting. Any issues will be immediately addressed and corrected. 2. Results\issues identified will be discussed with the IDT at monthly QA meetings and with the Medical Director at the Quarterly QA meeting and\or as needed for determination for ongoing monitoring and\or changes to the QA meeting.</p> <p>It is the intent of this facility to be able to demonstrate how the load test was calculated of the load capacity. Corrective Actions: 1. Maintenance Director has been trained and educated on the determination kw load on the generator load testing. 2. A Kw load calculation form has been provided and posted at the transfer switch. 3. Results of the test will be documented in the designated binder on the generator monthly test form.</p>	11/05/2015

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	<p>NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 10/19/15 at 4:04 p.m. with the Maintenance Supervisor, the amperage during load could not be verified to be at thirty percent of the EPS nameplate rating for the past twelve months and no other method was used to document monthly load. Based on interview on 10/19/15 concurrent with record review with the Maintenance Supervisor, it was</p>		<p>Others Identified: 1. No other findings. Systems in Place: 1. Kw load calculation posted for formula and documentation on the generator monthly test form. Monitoring: 1. Administrator/Designee will review generator monthly test form. Any issues will be immediately addressed and corrected. 2. Results/issues identified will be discussed with the IDT at monthly QA meetings and with the Medical Director at te quarterly QA meeting and/or as needed for determination for ongoing monitoring and/or changes to the QA meeting.</p>	

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	acknowledged the facility had been running the generator monthly but could not demonstrate how 30 percent load was calculated and no other equivalent method was used to comply with percentage of load capacity for the past twelve months.  3.1-19(b)				