

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
--	---

(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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<p>A Post Survey Revisit to the Life Safety Code Recertification and State Licensure Survey conducted on 05/21/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/06/15</p> <p>Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650</p> <p>At this PSR survey, The Waters of Covington was found in substantial 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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident sleeping rooms are equipped with battery powered smoke</p>	K 0000	<p>K000 The Creation and submission of this plan of correction does not constitute an admission of by this provider or any conclusion set forth in the statement of deficiencies, or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests a desk review certification of compliance on or after July 20, 2015</p>	
------------------------	---	--------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
--	---

(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
K 0025 SS=B Bldg. 01	<p>detectors. The facility has the capacity for 119 and had a census of 97 at the time of this survey.</p> <p>All areas with resident access were sprinklered. All areas providing facility services were sprinklered except a detached smoke hut and storage shed.</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>Based on observation and interview, the facility failed to ensure 3 of 3 openings in a smoke partition, such as a ceiling and wall, were sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and 10 or more residents on the Fountainview wing.</p>	K 0025	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The cutout in the drywall in fountain wing mechanical room and environmental services director office ceiling has been properly sealed with dry wall and fire rated caulking. How other residents having the potential to be</p>	07/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932
--	---

(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
	<p>Findings include:</p> <p>Based on observation with the administrator on 07/06/15 at 1:30 p.m., the cutout in the drywall for four pipe penetrations and the penetration of the same ceiling in the Fountainview mechanical room ceiling was sealed with a reddish colored expandable foam; on 07/06/15 at 1:45 p.m. the six inch duct penetration of the environmental services director was sealed in the same way. The maintenance director acknowledged at the time of observation, the penetrations were sealed with an expandable foam. He said the foam was, "fire rated" and produced a can of the material used, a DAP Fireblock. The fine print on the back of the can noted the product was, "not for commercial code application, not a fire stop sealant as defined by the UL", and "was extremely flammable when dispensing." The maintenance director said at the time of examining the product information, he had not read the fine print and was unaware it was not to be used for sealing penetration gaps in the ceiling. The administrator acknowledged at the time of reviewing the product information, the wrong sealant had been used.</p> <p>This deficiency was cited on 04/21/15. The facility failed to implement a</p>		<p>affected by the same deficient practice will be identified and what corrective action(s) will be taken? The maintenance director and HFA shall examine all areas of the building to ensure there are no other penetrations. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director shall conduct monthly rounds to ensure there are no penetrations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director shall report any issues to the Quality Assurance Committee. The Quality Assurance Committee shall provide suggestions if necessary. What date the systemic changes will be completed? July 20, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155223	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/06/2015
NAME OF PROVIDER OR SUPPLIER WATERS OF COVINGTON, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 E LIBERTY ST COVINGTON, IN 47932		
(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	
	systemic plan of correction to prevent recurrence. 3.1-19(b)				