STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155233	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF BATESVILLE THE	958 E HWY 46 BATESVILLE, IN 47006

(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	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/27/12 Facility Number: 000138 Provider Number: 155233 AIM Number: 100266500 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Batesville 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. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in	K0000	Preparation 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 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 defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER WATERS OF BATESVILLE THE		STREET ADDRESS, CITY, STATE, ZIP CODE 958 E HWY 46 BATESVILLE, IN 47006	

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	all resident sleeping rooms. The facility has a capacity of 86 and had a census of 68 at the time of this visit. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where residents have customary access were sprinklered except the outside smokers building and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/31/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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	155233		08/27/2012

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K0029 SS=E	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 Based on observation, interview and record review; the facility failed to ensure 1 of 1 rolling fire doors was maintained in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 54 residents who use	K0029	**K 029 NFPA 101 LIFE SAFETY CODE STANDARD** It is the intent of this facility to ensure the rolling fire door between dining room and kitchen is inspected and tested annually for proper operation and full closure in accordance with NFPA 80, LSC 4.5.7. **1. Actions Taken:** A licensed contractor inspected rolling fire door in question to meet set standards. **2. Others Identified:** Per the 2567, this potentially affected all residents. No further review was needed.	09/26/2012

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	the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 08/27/12 at 10:15 a.m. with the maintenance supervisor, the rolling fire door protecting the opening from the kitchen to the main dining room lacked an attached inspection tag. Based on interview on 08/27/12 during Fire Safety record review at 9:45 a.m. with the maintenance supervisor, it was acknowledged there was no documentation of an annual inspection or test to check for proper operation and full closure of the kitchen vertical rolling fire door. 3.1-19(b)		- **3. Measures Taken:** An annual inspection of the rolling fire door between dining room and kitchen was conducted to check for proper operation and full closure in accordance with NFPA 80, LSC 4.5.7. - **4. How Monitored:** The Maintenance Director is responsible for on-going compliance. The CEO will review with the Maintenance Director one month prior to and then after the next annual inspection is completed. This will be reviewed at the next four Quarterly QA committee meetings to ensure compliance. **5.** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 26, 2012	