

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  10/03/2014
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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: 10/03/14</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, 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. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is October 21, 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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K010025 SS=E	<p>sleeping rooms. The facility has the capacity for 100 and had a census of 81 at the time of this survey.</p> <p>All areas with customary access to residents were sprinklered. Three detached equipment storage sheds were unsprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/10/14.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by the following:</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 openings through 2 of 4 smoke barriers were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1</p>	K010025	<p>It is the intent of this facility to ensure that smoke barriers are protected to maintain the smoke resistance of the smoke barrier.</p> <p>1. Action Taken: Fire Caulk was applied to the attic smoke barriers above Moonlight Bay and</p>	10/08/2014			

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	<p>requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 10 or more residents in the Clearwater Cove and Moon Bay smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 10/03/14 between 11:30 a.m. and 2:30 p.m. attic smoke barriers above the Moonlight Bay and Clearwater Cove smoke barrier doors were penetrated by wiring and cables around which one and two inch gaps were unsealed. The maintenance director agreed at the times of observation the gaps should have been sealed with a fire rated material.</p> <p>3.1-19(b)</p>		<p>Clearwater Cove smoke barrier doors. 2. Others Identified: 100% audit of attic smoke barriers with no other findings. 3. Systems in Place: a. Maintenance Director will inspect attic after any contracted vendor enters attic. b. Maintenance Director will repair any identified areas. 4. Monitoring: a. Maintenance Director\Designee will complete an audit to ensure that all smoke barriers are protected to maintain the smoke resistance 2 times a week for 8 weeks, 1 time a week for 8 weeks, and monthly thereafter. B. Administrator\Designee will review all audits as completed in daily QA stand up meeting. Any issues will be immediately addressed and corrected. C. Results\issues identified will be discussed with IDT at monthly QA meeting 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. 5. Date of compliance: October 8, 2014</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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