

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2014
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NAME OF PROVIDER OR SUPPLIER  WATERS OF DUNELAND THE	STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304
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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). Survey Date: 10/01/14</p> <p>Facility Number: 000150 Provider Number: 155246 AIM Number: 100267000</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety survey, The Waters of Duneland 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and areas open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity</p>	K010000	000-Preparation and/or execution of the plan of correction in general, or this corrective action in particular does not constitute an admission agreement by the facility of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This POC is to serve as the Waters of Duneland's credible allegation of compliance.	

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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K010018 SS=E	<p>for 100 and had a census of 81 at the time of this survey.</p> <p>Areas where residents have customary access were sprinklered except the smoke hut and the shower room cited at K56. All areas providing facility services were sprinklered.</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 regulatory requirements as evidenced by the following:</p> <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.</p>			

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	<p>Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 5 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in the dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/01/14 at 11:45 a.m., the double door set providing access to the employee lounge required one door to latch into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The first door had a slide bolt at the bottom of the door to secure it into the door frame and the remnants of an automatic door latch at the top of the door. The maintenance director acknowledged at the time of observation, each door could not latch automatically into the door frame.</p> <p>3.1-19(b)</p>	K010018	0018-It is the policy of the Waters of Duneland to ensure door latches are working properly. A new latch has been installed to insure the door closes properly. No residents were affected by the missing door latch. To prevent a reoccurrence, The maintenance director will inspect doors monthly, to ensure door latches are present and working properly (See Exhibit A-Preventative Maintenance Checklist). The Quality Assurance Committee will oversee the Maintenance Director and monthly maintenance checklist (See Exhibit B-Quality Assurance Note).	10/31/2014

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K010025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 ceiling and wall smoke barrier penetrations in 1 of 5 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so 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. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to floor and outside wall to outside wall. This deficient could affect visitors, staff and 10 or more residents in the 100, 200 300</p>	K010025	<p>K0025-It is the policy of the Waters of Duneland to ensure fire safety by having no fire wall penetrations. The building has been inspected and all firewall penetrations have been sealed with fire proof caulking. No residents were affected by the deficient practice. To prevent a reoccurrence, the maintenance director will inspect the building monthly, observing for any breaches in the fire walls (See Exhibit A-Preventative Maintenance Checklist). The Quality Assurance Committee will oversee the Maintenance Director (See Exhibit B) for monthly preventative maintenance checklist.</p>	10/31/2014

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	<p>and 400 halls.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/01/14 between 11:30 a.m. and 2:30 p.m., the following ceiling penetrations were found:</p> <p>a. Unsealed around two inch pipes in janitor's closets on the 100, 200, 300 and 400 halls leaving one half inch annular gaps into the attic above;</p> <p>b. An unsealed one fourth annular gap around a two inch pipe penetration in the 100 hall linen room near 108;</p> <p>c. Three unsealed ceiling conduit penetrations by emergency generator conduit in the 100 hall mechanical/electrical room which left half inch gaps into the attic;</p> <p>d. A conduit penetration gap sealed with expandable foam in the nurses station medicine room;</p> <p>e. An eight inch duct penetration above the commercial dryers sealed with expandable foam in the laundry;</p> <p>f. One half inch annular gaps to one side of pendant sprinkler escutcheons in the main dining room and in the</p>			
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K010038 SS=E	<p>corridor outside the 100 hall mechanical room, The maintenance director acknowledged the unsealed gaps and foam material used to seal penetrations at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 7 exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 10 or more residents on the 200 and 300 halls.</p> <p>Findings include:</p>	K010038	0038-It is the practice of The Waters of Duneland to ensure a safe exit from the facility. The sidewalk does not prevent an egress from the building. No residents were affected. The Waters of Duneland has obtained a contractor who will replace the asphalt sidewalk, a bid and agreement to have work performed has been signed and approved (Exhibit H), however, the contractor will be unable to complete the job, because of shortage of asphalt and season/weather. The contractor will be able to complete the job in the spring. Therefore, The Waters of Duneland is requesting a waiver, on date of job	11/07/2014

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K010048 SS=F	<p>Based on observation with the maintenance director and administrator on 10/01/14 between 11:30 a.m. and 2:30 p.m., the asphalt exit discharge surfaces for the emergency exterior exits from the 200 and 300 halls were damaged across the width of the exit discharge surfaces by pitting, irregular cracks and areas which had broken away which made the surface not level. The maintenance director said at the time of observation, the damage had been assessed and the facility planned to provide level surfaces for these exits.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>1. Based on record review and interview, the facility failed to include a single written fire plan for the protection of 81 of 81 residents in the event of an emergency addressing all required elements, including the types and locations of fire extinguishers. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire</p>	K010048	<p>completion(Waiver included in attachments). Since the marred sidewalks do not prevent egress from the building, a waiver would not cause or endanger exit from the facility in an emergency.</p> <p>K0048-It is the practice of the Waters of Duneland to have a complete Fire Disaster Plan for the protection of all patients and for their evacuation in the event of an emergency. The facility disaster plan was updated and does include: 1. Procedures for dietary staff regarding use of Ansul system and K-extinguisher. All dietary staff will be trained regarding kitchen fire procedures by 10/31/14 (See Exhibit F). Staff will be trained on an annual basis to ensure they</p>	10/31/2014

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	<p>department</p> <p>(3) Response to alarms</p> <p>(4) Isolation of fire</p> <p>(5) Evacuation of immediate area</p> <p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>a. Based on review of the Fire Plan with the maintenance director and administrator on 10/01/14 at 2:50 p.m., the fire safety plan referred to the use of Class A fire extinguisher. The maintenance director said at the time of record review these types of extinguishers were not available in the facility. In addition, the Fire Plan did not address the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The locations of the ABC fire extinguishers were noted as, "usually located at the nurses station, laundry and kitchen. Additional pages in the disaster manual gave reference to Class B fire extinguishers which the maintenance director confirmed were not available for use. The maintenance director agreed at the time of record</p>		<p>are familiar with kitchen fire procedures. 2. Locations of Fire Extinguishers and types of Fire Extinguishers in house. Evacuation routes for partial and full evacuations (Exhibit C), off-site evacuation site and transportation in the event of emergency. No residents were affected by the deficient practice. To ensure compliance, the Quality Assurance Committee will oversee the annual disaster plan is reviewed and updated as needed, and annual fire training (See Exhibit B).</p>				

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	<p>review the actual locations of fire extinguishers available should have been identified. He acknowledged the written fire safety plan did not mention the kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</p> <p>b. Based on review of the Fire Plan with the maintenance director and administrator on 10/01/14 at 2:50 p.m., the procedure noted, "if a fire is small and controllable,..." and directions for smothering a fire. The maintenance director said at the time of record review, staff were not trained fire fighters in identifying the extent of fire and their training did not include competency or use of fire extinguishers.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide a written plan which included the the means of evacuating residents to alternate sites in the event of an emergency for the protection of 81 of 81 residents. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility Disaster Plan with the maintenance director and</p>			

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K010056 SS=E	<p>administrator on 10/01/14 at 2:45 p.m., the facility evacuation plan was incomplete. The plan included a contract for relocation of residents to a place of off site refuge at area schools in the event of an emergency. However there was no contract for the transportation of the residents to these facilities. The administrator said at the time of record review he had no documentation of transportation arrangements for residents to off site facilities in the event of an emergency. The maintenance director said at the time of record review, the facility had a bus which could carry 16 ambulatory and two wheelchair bound residents. He acknowledged other means of transport could be needed for the remainder of the residents and this element of an evacuation plan was not addressed in the disaster plan.</p> <p>3.1-19(b)</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</p>			

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	<p>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 provide complete sprinkler coverage for 1 of 5 smoke compartments in a one story building of Type V (000) construction. LSC 19.1.6.2 requires one story facilities of Type V (000) construction be provided with complete sprinkler protection. This deficient practice affects visitors, staff, and 10 or more residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/01/14 at 12:45 p.m., sprinkler protection was not provided for the center shower stall in a row of three shower stalls on the 200 hall. The maintenance director acknowledged at the time of observation, the area was not protected by the other sprinklers in the room.</p> <p>3.1-19(b)</p>	K010056	0056-It is the practice of the Waters of Duneland to ensure complete sprinkler coverage. The shower room sprinkler head has been relocated inside the shower bay to ensure sprinkler coverage for that area (See Exhibit D-Safecare Documentation). No residents were affected by the deficient practice. To prevent a reoccurrence, the maintenance director will check sprinkler heads monthly (See Exhibit A) and the Quality Assurance Committee will oversee the maintenance director's compliance (See Exhibit B).	10/31/2014

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K010064 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation, the facility failed to ensure portable fire extinguishers in 3 of 5 smoke compartments were installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects visitors, staff and 10 or more residents in the 100, 200 and 300 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/01/14 between 11:30 a.m. and 2:30 p.m., a portable fire extinguisher was measured at: 66.5 inches above the finished floor near the employee exit. Two portable fire extinguishers in the kitchen, two extinguishers in the restorative dining room, and a fire</p>	K010064	0064-It is the practice of the Waters of Duneland to ensure fire extinguisher placement is in accordance with NFPA 10. The fire extinguisher shelves are being lowered to meet the requirement of 60 inches above floor The maintenance director will have all extinguisher shelves scheduled for lowing by 10/31/14, and the work is expected to be completed by 11/30/14 (See Exhibit E-Calender for scheduled fire extinguisher shelf lowering). No residents were affected by the deficient practice. To prevent a reoccurrence, the maintenance director will monitor the fire extinguishers monthly, to ensure proper placement (See Exhibit A). The Quality Assurance Committee will oversee the maintenance director's compliance (See Exhibit B).	10/31/2014			

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K010143 SS=E	<p>extinguisher near room 110, near the 100 hall nurses station, near 204, and near room 308 were each measured 65 inches above the finished floor. The maintenance director acknowledged at the time of observations, the height of these extinguishers exceeded the maximum 60 inch height permitted.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 rooms where liquid oxygen transferring takes place was provided with continuous mechanical ventilation to the outside and</p>	K010143	00143-It is the practice of The Waters of Duneland to ensure oxygen storage room is vented to the outside. A continuous running mechanical vent is now installed. An additional 5/8	10/31/2014

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	<p>separated from any portion of the facility wherein residents are housed by a fire barrier of 1 hour fire resistive construction. This deficient practice affects staff, visitors and 10 or more residents in the 100 hall smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/01/14 at 12:10 p.m., the oxygen transfer and storage room located in the 100 hall smoke compartment near the main dining room was identified by the maintenance supervisor. There was no mechanical vent for the room, only a 12 inch square vent cut into one wall of the room. Upon closer inspection at the ceiling was constructed of a single sheet of drywall which did not provide the room with the required one hour fire protection. The maintenance director said at the time of observation, he did not know a mechanical vent and additional drywall for the ceiling was needed to provide the protection required for the oxygen transfilling room.</p> <p>3.1-19(b)</p>		<p>plywood has been added to the ceiling creating a 1 hour fire barrier. No residents were affected. The corrective action is a structural change to the building. These changes are permanent, but the maintenance director will monitor the vent monthly to ensure it is working properly (See Exhibit A). The Quality Assurance Committee will oversee the maintenance director's compliance (See Exhibit B).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2014
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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 5 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment housing 200 and 400 hall sleeping rooms.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 10/01/14 between 11:30 a.m. and 2:30 p.m., the mechanical/electrical room housing electrical circuit panels and</p>	K010147	00147-It is the practice of the Waters of Duneland to ensure Electrical Wiring and equipment in accordance with NFPA 70. The Storage in the room housing the electrical panels has been cleared of all storage items allowing the required 3 feet of access space and all extension cords have been removed. The power-strips to the vending machines, washing machines, microwave, battery charger, and refrigerator. The maintenance director has been inserviced regarding need to keep electrical panels uncluttered, non-use of extension cords and proper use of power-strips (Exhibit G). No residents were affected by the deficient practice. To prevent a reoccurrence, the maintenance director will monitor the storage room at a minimum of monthly (See Exhibit A). The Quality Assurance Committee will oversee the maintenance director's compliance (See Exhibit B).	10/31/2014

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	<p>emergency generator transfer switches was filled with stored items in cardboard boxes and a maintenance utility cart located immediately against the panels and less than the minimum three foot distance required for access. The maintenance director acknowledged at the time of observation, the had asked staff repeatedly to keep the room free of storage.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring in 3 of 5 smoke compartments. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff and 10 or more residents in the 100, 200, and 400 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the</p>			

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	<p>maintenance director and administrator on 10/01/14 between 11:30 a.m. and 2:30 p.m.:</p> <ul style="list-style-type: none"> <li>a. Two commercial vending machines located in the 100 hall smoke compartment were plugged into a power strip extension cord for a power supply;</li> <li>b. An extension cord lay on the floor to supply power to a dehumidifier in the dishwashing area of the kitchen;</li> <li>c. A multiplug adapter was used to supply power to two commercial washing machines in the laundry;</li> <li>d. A powerstrip extension cord was used to supply power to a microwave oven in resident room 210;</li> <li>e. A powerstrip was piggybacked to a second power strip to supply power for charging batteries for medical equipment in the nurses station medicine room;</li> <li>f. An extension cord supplied power for a "breathing machine" and lamp in resident room 402.</li> <li>e. Power strip extension cords to supply power to refrigerators in the MDS office and Activities room;</li> </ul> <p>The maintenance acknowledged the use of the above noted equipment at the time of observations.</p> <p>3.1-19(b)</p>			

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