

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 07/28/2016
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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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(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 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: 07/28/16</p> <p>Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290</p> <p>At this Life Safety Code survey, Waters of Greencastle, 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 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 78 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.	

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 0062 SS=B 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 08/12/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler heads in resident room # 215 was free of obstruction which would interfere with the spray pattern of the sprinkler head from fully developing. This deficient practice could affect 22 residents on south 200 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/28/16 at 1:48 p.m. with the Maintenance Supervisor, the sprinkler head located in the south part of the ceiling of resident room # 215 was positioned above the ceiling drywall.</p>	K 0062	<p>It is the policy of the facility to ensure that the required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. Action Taken: The Sprinkler head located in the south part of the ceiling of resident room #215 was repaired\fixed and free of obstruction. Others Identified: 100% audit of sprinkler heads and no additional obstructions were identified. Systems in Place: Maintenance Director will inspect sprinkler heads during preventative maintenance rounds and repair any identified areas. Monitoring: a) Maintenance Director\Designee</p>	08/25/2016

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	Based on interview concurrent with the observation 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. 3.1-19(b)		will complete an audit to ensure that all sprinkler heads are free of obstruction 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.		