STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 01 B. WING	09/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

(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	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: 09/14/15 Facility Number: 000478 Provider Number: 155494 AIM Number: 100290430 At this Life Safety Code survey, The Waters of Scottsburg 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 (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 99 and had a census of 77 at the time of this visit.	K 0000	Preparation and/or execution of this plan of correction in general, or this corective 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 wiht 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

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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden shed and a detached twenty foot by thirty foot metal storage building which were not sprinkled. Quality Review completed 09/22/15 - DA			
K 0018 SS=E Bldg. 01	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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure the 2 of 98 corridor room doors were provided with a suitable means for keeping the doors closed. This deficient practice affects any residents who use the Administration Hall and 2 residents who reside in room 117.	K 0018	The gaps on the two doors preventing full closure were fixed on 09/15/2015. An audit of all doors in the facility was completed with no other findings noted.Maintanance or designee will audit all doors for full closure 5x/week during daily PM rounds to monitor for future concerns with this deficiency. This audit will	10/05/2015

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	Findings include: Based on observations with the maintenance supervisor on 09/14/15 during a tour of the facility from 11:20 a.m. to 2:20 p.m., the Administration Hall conference room and resident room 117 each had a one inch gap along the latching sides of the doors and failed to latch and close into the door frames. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/14/15 at 2:30 p.m. 3.1-19(b)		be ongoing with no end date.Results of these audits will be reviewed monthly in QA meeting.	
K 0029 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinklered laundry room was separated	K 0029	The drywall was repaired to be within code on 09/17/2015. An audit of all walls completed to ensure wall barriers are	10/05/2015

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	from the Service Hall by smoke resistant partitions. This deficient practice could affect 47 residents who use the main dining room, located at the end of the Service Hall. Findings include: Based on observation on 09/14/15 at 12:20 p.m. with the maintenance supervisor, the laundry room south wall had five, one foot by one foot square sections of drywall missing with wooden studs exposed. Based on an interview with the maintenance supervisor on 09/14/15 at 12:30 p.m., the drywall was cut out to repair water pipe damage six months ago and has not been repaired. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/14/15 at 2:30 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 5 hazardous areas, such as a storage room for combustibles over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any residents who		partitioned per code and no damage noted. No other concerns were noted. Maintanence or designee will monitor this 5x/week during daily PM rounds and concerns will be fixed in a timely manner. This audit will be ongoing with no stop date. Results of audits to be reviewed monthly in QA.	

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	use the Administration Hall. Findings include: Based on observation on 09/14/15 at 11:40 a.m. with the maintenance supervisor, the Administration Hall medical records room, which each measured one hundred sixty eight square feet and stored twenty seven cardboard boxes of paper medical records, lacked a self closing device on the door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/14/15 at 2:30 p.m. 3.1-19(b)			
K 0038 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure the sidewalk surface on 1 of 9 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be	K 0038	This sidewalk is not used by residents or public at this time. Quotes being obtained to fix the damaged concrete on the sidewalk. This will be repaired by 10/12/2015. Audit of other sidewalks completed with no other damaged areas noted.Maintanance or designee will monitor for cracked/damaged areas on sidewalk 5x/week during PM rounds and deficiencies will be repaired in a timely	10/12/2015

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	considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice affects 27 residents who reside on the Emerald Hall. Findings include: Based on observation with the maintenance supervisor on 09/14/15 at 1:20 p.m., the Emerald Hall exit sidewalk had a four foot by two foot section of concrete sidewalk broken in three locations with two inch elevation changes where the sidewalk met the paved parking lot. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/14/15 at 2:30 p.m. 3.1-19(b)		manner.Results of monitoring will be reviewed monthly in QA meeting.	
K 0062 SS=F Bldg. 01	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 Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance	K 0062	The noted sprinkler head has been replaced and within code. An audit of all sprinkler heads completed with 2 other heads noted to have paint on them. These sprinkler heads have also been replaced at this	10/05/2015

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	of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the maintenance supervisor on 09/14/15 at 11:05 a.m., there was no documentation to indicate an internal inspection of the dry sprinkler system had been conducted within the past five years. Based on an interview with the maintenance supervisor on 09/14/15 at 11:10 a.m., the maintenance supervisor stated Safecare indicated on their last visit an internal pipe inspection is overdue on the dry sprinkler system. The lack of a five year internal pipe inspection was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 09/14/15 at 2:30 p.m. 3.1-19(b)		time. Maintanence or designee will audit for this deficiency 5x/week during daily PM rounds and concerns addressed timely.Results of this monitoring will be reviewed monthly in QA.	
K 0143 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (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;			

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	(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (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 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer locations was provided with mechanical ventilation. This deficient practice could affect any residents who use the Administration Hall where the liquid oxygen storage room is located. Findings include: Based on observation with the maintenance supervisor on 09/14/15 at 11:45 a.m., the Administration Hall liquid oxygen storage location, where three full liquid oxygen containers were stored, had an exhaust fan mounted in the ceiling which was not functioning. Based on an interview with the maintenance supervisor on 09/14/15 at 11:50 a.m., the ceiling exhaust fan stopped working two weeks ago and has not been repaired yet. Furthermore, the maintenance supervisor indicated during the interview nursing staff transfers liquid oxygen from the large containers	K 0143	This deficiency has been fixed/repaired at this time. This is the only oxygen storage room in the facility.Maintanence or designee will monitor the functioning of the ventilation in the oxygen room 5x/week during daily PM rounds and concerns addressed timely.Results will be reviewed monthly in QA meeting.	10/05/2015

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	to small portable containers in the liquid oxygen storage room. The lack of mechanical ventilation in the liquid oxygen storage room was verified by the maintenance supervisor at the time of observation and interview and acknowledged by the administrator at the exit conference on 09/14/15 at 2:30 p.m. 3.1-19(b)			