STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILLS CARE CENTER	403 BIELBY RD LAWRENCEBURG, IN 47025

(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
K010000	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: 01/21/15 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code Survey, Woodland Hills Care Center 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 three story facility with a basement was determined to be of Type II (222) construction and fully sprinkled except resident room 112B two closets. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open	K010000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under the state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus , the facility respectfully request the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.	

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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	to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 40 at the time of this survey. All areas providing facility services were sprinkled and all areas where residents have customary access were sprinkled except the two closets in resident room 112B. Quality Review by Dennis Austill, Life Safety Code Specialist on 01/27/15. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	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.			

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	Based on observation and interview, the facility failed to ensure 1 of 3 clean utility room corridor doors would latch and resist the passage of smoke. This deficient practice affects 30 residents who reside on the first floor. Findings include: Based on observation on 01/21/15 at 11:10 a.m. with the maintenance supervisor, the first floor clean utility room door had a two inch gap from the bottom of the door to the latch. Furthermore, the first floor clean utility room door failed to latch into the door frame on two separate attempts. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 01/21/15 at 3:50 p.m. 3.1-19(b)	K010018	1 The first floor clean utility room door was replaced eliminating the two inch gap from the bottom of the door to the latch. 2. Furthermore, a closure was installed to ensure the door latched to the frame each time it closes. 3.The administrator or designee will conduct daily rounds ensuring that there are no further issues. The rounds tool will be reviewed each morning during stand up meeting and quarterly during QA&A meetings 4 The maintenance staff was in-serviced regarding Door Standards for LIFE SAFETY CODE. 5. The above corrective action measures were completed on January 27, 2015.	01/27/2015
K010029 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			

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	protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 4 of 8 hazardous areas, such as a fuel fired equipment rooms and combustible storage rooms over 50 square feet, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames or lacked latching hardware. This deficient practice could affect 6 residents who use the respiratory therapy room and 29 residents who reside on the second floor near the soiled linen room. Findings include: Based on observations on 01/21/15 during a tour of the facility with the maintenance supervisor from 9:45 a.m. to 3:30 p.m., the following hazardous area doors were either not equipped with self closing devices or lacked latching hardware: a. The basement respiratory therapy storage room, which measured two hundred twenty square feet and had eighteen shelves of combustible plastic respiratory equipment stored in cardboard boxes, lacked a self closing device on the door. b. The basement medical records storage	K010029	a). 1. THE BASEMENT RESPIRATORY THERAPY STORAGE ROOM was lacking closure device. 2. Furthermore, a closure was installed to ensure the door latched to the frame each time it closes. 3.The administrator or designee will conduct daily rounds ensuring that there are no further issues. The rounds tool will be reviewed each morning during stand up meeting and quarterly during QA&A meetings 4 The maintenance staff was in-serviced regarding Door Standards for LIFE SAFETY CODE. 5. The above corrective action measures were completed on January 26, 2015. b). 1. BASEMENT MEDICAL RECORD STORAGE ROOM was lacking closure device. 2. Furthermore, a closure was installed to ensure the door latched to the frame each time it closes. 3.The administrator or designee will conduct daily rounds ensuring that there are no further issues. The rounds tool will be reviewed each morning during stand up meeting and quarterly during QA&A meetings 4 The maintenance staff was in-serviced regarding Door Standards for LIFE SAFETY CODE. 5. The above corrective action measures were completed on January 26, 2015. c).	01/26/2015

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	room, which measured one hundred eighty square feet and stored twenty four shelves of paper medical records in cardboard boxes, lacked a self closing device on the door. c. The basement east natural gas furnace room door lacked a self closing device. d. The second floor soiled linen room door lacked latching hardware. The basement respiratory therapy storage room door, basement medical records room door, and the basement east natural gas furnace room door lacking self closing devices and the second floor soiled linen room door lacking latching hardware was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 01/21/15 at 3:40 p.m. 3.1-19(b)		1. BASEMENT EAST NATURAL GAS FURNACE ROOM was lacking closure device. 2. Furthermore, a closure was installed to ensure the door latched to the frame each time it closes. 3.The administrator or designee will conduct daily rounds ensuring that there are no further issues. The rounds tool will be reviewed each morning during stand up meeting and quarterly during QA&A meetings 4 The maintenance staff was in-serviced regarding Door Standards for LIFE SAFETY CODE. 5. The above corrective action measures were completed on January 26, 2015. d). 1. SECOND FLOOR SOILDED UTILITY ROOM was lacking latching hardware device. 2. Furthermore, a new latching hardware was installed to ensure the door latched to the frame each time it closes. 3.The administrator or designee will conduct daily rounds ensuring that there are no further issues. The rounds tool will be reviewed each morning during stand up meeting and quarterly during QA&A meetings 4 The maintenance staff was in-serviced regarding Door Standards for LIFE SAFETY CODE. 5. The above corrective action measures were completed on January 26, 2015. .	
K010056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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	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 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			
	Based on observation and interview, the facility failed to ensure 2 of 2 closets in resident room 112B were sprinkled. This deficient practice affects 2 residents who reside in resident room 112B. Findings include: Based on observation on 01/21/15 at 11:50 a.m. with the maintenance supervisor,the two closets in resident room 112B lacked sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 01/21/15 at 3:40 p.m. 3.1-19(b)	K010056	1. 2 of 2 closets in resident room 112B were not sprinkled. This deficient practice affects 2 residents who reside in room 112b 2.Furthermore, Elwood Fire Equipment Company Will Install sprinkler heads in each closet (see attachment a). 3.The administrator or designee will conduct daily rounds ensuring that there are no further issues. The rounds tool will be reviewed each morning during stand up meeting and quarterly during QA&A meetings 4 The maintenance staff was in-serviced on sprinkler requirements per LIFE SAFETY CODE. 5. The above corrective action measures will be completed no later than February 15, 2015.	02/15/2015