

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2016
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NAME OF PROVIDER OR SUPPLIER WHITE OAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960
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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: 04/14/16</p> <p>Facility Number: 012355 Provider Number: 155782 AIM Number: 201014410</p> <p>At this Life Safety Code survey, White Oak Health Campus 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story, fully sprinklered facility was determined to be Type V (111) construction. The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridors and resident rooms. The SNF certified health care occupancy was located on north end of the main building with the capacity for 61 residents and a</p>	K 0000	The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Life Safety Recertification and State Licensure Survey on April 14, 2016. Please accept this Plan of Correction as White Oak Health Campus' credible allegation of compliance effective May 14, 2016. White Oak Health Campus respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial 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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K 0027 SS=F Bldg. 01	<p>census of 55 at the time of this survey.</p> <p>All areas accessible to residents and areas providing facility services are sprinklered.</p> <p>Quality Review on 04/15/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 sets of smoke barrier doors and 1 of 4 sets of fire barrier doors were equipped with rabbets, bevels, or astragals at the meeting edges. This deficient practice could affect all residents of the facility.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Director of Plant Operation on 04/14/16 between 10:00 a.m. and 11:30 a.m., all sets of smoke barrier doors in the facility and the fire</p>	K 0027	<p>1. All smoke barrier doors equipped with astrigals at the meeting edges of the door. 2. This alleged deficient practice has the potential to affect all residents. 3. All smoke barrier doors reviewed to ensure no gap between doors when closed. Director of Plant Operations (DPO) or designee will review at least monthly on preventative maintenance schedule to ensure proper closing of smoke barrier doors. 4. Trends will be brought to monthly QA committee x six months or until 100% compliance is achieved.</p>	05/14/2016

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K 0029 SS=E Bldg. 01	<p>door set in the main hall were not equipped with rabbets, bevels, or astragals at the meeting edges of the doors. Based on interview at the time of observation, the Director of Plant Operation acknowledged that none of the smoke barrier doors in the facility nor the fire door in the main hall were equipped with rabbets, bevels, or astragals at the meeting edges of the doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 2 of 2 storage rooms with combustibles, measuring over 50 square feet in size, were provided with a self-closing device. This deficient practice could affect up to 10 resident evacuating through the main entrance.</p> <p>Findings include:</p>	K 0029	<p>1. Self closing device installed on front office work room & Medical Records office door. 2. The alleged deficient practice has the potential to affect all residents. 3. All self closing doors will be reviewed monthly on preventative maintenance schedule by Director of Plant Operations (DPO) or designee. 4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x six months or until 100% compliance is</p>	05/14/2016

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K 0044 SS=E Bldg. 01	<p>Based on observation during a tour of the facility with the Director of Plant Operations on 04/14/16 from 10:15 a.m. to 11:00 a.m., the corridor door to the following rooms with combustible storage, measuring over 50 square feet in size, lacked a self-closing device:</p> <p>a) The work room by the main entrance containing two plastic 80 gallon containers of paper.</p> <p>b) The medical records room containing 16 cardboard boxes with paper records. Based on interview at the time of observation, this was confirmed by the Director of Plant Operations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch</p>	K 0044	<p>achieved.</p> <p>1. Fire door in dining room leading to kitchen that separates healthcare & assisted living fixed to ensure proper self closing. 2. This alleged deficient practice has the potential to affect all residents. 3. Fire door cited and all other applicable fire doors reviewed at least monthly on preventative maintenance schedule to ensure proper closing. 4. Trends will be brought to monthly Quality Assurance meeting for review by QA committee x six months or until</p>	05/14/2016

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	<p>mechanism so that positive latching is achieved on each door operation. This deficient practice could affect up to 30 residents in main dining room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Operations on 04/14/16 at 10:35 a.m., the fire door in the dining room leading to the kitchen that separates health care from assisted living failed to latch into the frame. Based on interview at the time of observation, the Director of Plant Operations acknowledged the door was a fire door and not latching into the frame.</p> <p>3.1-19(b)</p>		100% compliance is achieved.		