

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(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
--------------------	--	---------------	---	----------------------

K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 07/19/12</p> <p>Facility Number: 000681 Provider Number: 155549 AIM Number: 100286100</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Quality Assurance Walk-thru survey, Willowbend Living Center was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. None of the resident rooms are provided with smoke detection. The facility has a capacity of 60 and had a census of 47 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage, however, it was not in compliance with state law in regard to smoke detector</p>	K0000		
-------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>coverage.</p> <p>All areas where the residents have customary access were sprinklered. The facility had two detached barns for facility storage which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/23/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/19/2012	
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302			
(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			
K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by:</p> <p>Based on observation and interview, the facility failed to install smoke detectors in each resident's room before July 1, 2012. This deficient practice could affect at least 42 residents in the facility.</p> <p>Findings include:</p> <p>Based on observations with the</p>	K9999	<p>3.1-19 Environment and Physical Standards</p> <p>1. No residents were harmed.</p> <p>2. All residents have the potential to be affected. Smoke detectors were installed in all rooms. All smoke detectors were checked for proper placement and function.</p> <p>3. Smoke detectors were placed on preventative maintenance schedule for weekly checks and proper function. (see attachment A)</p> <p>4. All smoke detectors will be checked annually for proper function and cleaning. (see attachment A) This practice will be reviewed quarterly during Quality Assurance Meetings.</p> <p>5. The above corrections were made and completed on July 19, 2012.</p>	07/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155549	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/19/2012
NAME OF PROVIDER OR SUPPLIER WILLOWBEND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302		
(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	
	<p>Maintenance Supervisor on 07/19/12 from 12:30 p.m. to 1:15 p.m., the following resident rooms were not provided with smoke detectors: Resident rooms 101 through 136. Based on interview during the time of observations with the Maintenance Supervisor, it was acknowledged none of the resident rooms were provided with smoke detectors.</p> <p>3.1-19(ff)</p>				