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 03/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBEND LIVING CENTER	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
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: 03/31/14 Facility Number: 000681 Provider Number: 155549 AIM Number: 100286100 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Willowbend Living 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 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, in spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a	K010000	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

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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	capacity of 60 and had a census of 39 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the two detached barns used for facility storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/15/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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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 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 1 of 1 doors leading to hazardous areas on the Administrative hall, such as rooms with combustible items, was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 11 residents on 100 hall south as well as visitors and staff. Findings include: Based on observation on 03/31/14 at 12:55 p.m. with the Maintenance Supervisor, the Respiratory office on Administrative hall contained twenty two cardboard boxes inside the room which was greater than fifty square feet in size and did not have a self closing device on the corridor door. Based on interview on 03/31/14 at 12:58 p.m. with the	K010029	1. No resident was affected by this alleged deficient practice. A self closing device has been placed on the door leading to the Respiratory office. The cardboard boxes have been removed and supplies are being stored in totes.2. In an effort to identify any other issues with the doors, an observation by the Maintenance Director and Administrator of all rooms containing combustible items to ensure a self closing device is in place on the door with no additional findings.3. In an effort to ensure ongoing compliance, the Maintenance Director was re-educated on the Life Safety Code Standard for self closing devices on doors to rooms storing hazards/combustible items.4. As a means of Quality Assurance, the Maintenance Director or designee will do a monthly walk-through of the entire building checking doors and will document	04/23/2014

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	Maintenance Supervisor, it was acknowledged the aforementioned door leading into the aforementioned office containing combustible items was not equipped with a self closing device on the door. 3.1-19(b)		findings on the facility's preventative maintenance form. Any negative findings will be corrected and reported to the Administrator. Results of the monitoring will be reviewed in the facility's quarterly QA meeting for continued compliance, monitoring will be ongoing.	

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K010043 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2 Based on observation and interview, the facility failed to ensure 6 of 6 bathrooms on 100 hall south were arranged so the residents can open the door from inside without using a key. This deficient practice could affect 11 residents on the 100 hall south as well as visitors and staff. Findings include: Based on observations on 03/31/14 during the tour between 1:16 p.m. to 1:33 p.m. with the Maintenance Supervisor, the six bathrooms shared by eleven residents on the 100 hall south had a deadbolt lock on the entry side of each resident room door so if a resident was inside and both doors were deadbolted, an occupant could not get out without the use of a key, or tool to unlock the door from inside. Based on interview on 03/31/14 concurrent with the observations, it was acknowledged by the Maintenance Supervisor the deadbolts on the bathroom doors should be removed. 3.1-19(b)	K010043	1. No residents were affected by this alleged deficient practice. The deadbolt locks have been removed from the bathroom doors.2. In an effort to identify any other issues with locks on doors, an observation by the Administrator and Maintenance Director of resident room and resident bathroom doors has been completed with no additional findings.3. In an effort to ensure ongoing compliance, the Maintenance Director was re-educated on the Life Safety Code Standard for door locks.4. As a means of Quality Assurance, the Maintenance Director or designee will do a monthly walk-through of the entire building checking resident room/bathroom doors and will document findings on the facility's preventative maintenance form. Any negative findings will be corrected and reported to the Administrator. Results of the monitoring will be discussed during the facility's quarter QA meeting for continued compliance, monitoring will be ongoing.	04/23/2014

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K010144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This	K010144	1 & 2. No residents were affected but all have the potential to be affected by this alleged deficient practice. A load bank test on the generator was completed on 4/23/14.3. In an effort to ensure ongoing compliance, the Maintenance Director was re-educated on the Life Safety Code Standard for load testing of the generator.4. As a means of Quality Assurance, the Maintenance Director or designee will ensure load bank testing is completed per guidelines and will document findings on the facility's preventative maintenance form. Any negative findings will be corrected and reported to the Administrator. Results of the monitoring will be reviewed in the quarterly QA meetings for continued compliance, monitoring will be ongoing.	04/23/2014

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	deficient practice could affect all residents as well as staff and visitors. Findings include: Based on review of Generator System Testing records and Maintenance logs on 03/31/14 at 2:38 p.m. with the Maintenance Supervisor, the amperage during load was documented for the past twelve months, but it could not be verified to be 30 percent of the EPS nameplate rating. Based on interview on 03/31/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator and recording the amperage, but were unaware it had to get it to be at least 30 percent of the EPS nameplate rating. No other method was used to comply with percentage of load capacity for the past twelve months. 3.1-19(b)			

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K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 11 residents on 100 south hall as well as visitors and staff. Findings include: Based on observation on 03/31/14 at 2:21 p.m. with the Maintenance Supervisor, two extension cords used in the Maintenance office on 100 south hall were used to power a coffee maker, radio and microwave. Based on interview on 03/31/14 at 2:22 p.m. it was acknowledged by the Maintenance Supervisor, two extension cords were used to provide power to the aforementioned appliances and it was mentioned extension cords were not allowed in the facility. 3.1-19(b)	K010147	1. No residents were affected by the alleged deficient practice. The 2/2 extension cords have been removed from the facility. 2. In an effort to identify any other issues with flexible cords and cables, an observation by the Administrator and Maintenance Director of all areas has been completed with no additional findings.3. In an effort to ensure ongoing compliance, the Maintenance Director was re-educated on the Life Safety Code Standard for flexible cords and cables.4. As a means of Quality Assurance, the Maintenance Director or designee will do a monthly walk-through of the entire building checking for the use of flexible cords and cables and will document findings on the facility's preventative maintenance form. Any negative findings will be corrected and reported to the Administrator. Results of the monitoring will be reviewed during the facility's quarterly QA meetings for continued compliance, monitoring will be ongoing.	04/23/2014

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