

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  02/02/2012
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NAME OF PROVIDER OR SUPPLIER  WILLOWBEND LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7524 E JACKSON ST MUNCIE, IN 47302
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K0000	<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: 02/02/12</p> <p>Facility Number: 000681 Provider Number: 155549 AIM Number: 100286100</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this 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.</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. The facility has a capacity of 60 and had a census of 47 at the time of this survey.</p>	K0000		
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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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	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/03/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0018 SS=E	<p>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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 sets of corridor doors to the Dining room on South wing would latch into their frames and were smoke resistant. This deficient practice could affect 12 residents on South wing which is adjacent to the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 2/02/12 at 1:20 p.m. with the Maintenance Supervisor, the two sets of corridor doors leading into the Main dining room on South wing would not latch into their frames and had a one half inch gap between the doors when closed. Based on interview on 2/02/12 at 1:24 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned doors</p>	K0018	<p>1. No residents were affected by the alleged deficient finding. 2. All residents have the potential to be affected. The two (2) sets of corridor doors to the dining room have been repaired. The doors latch appropriately and are smoke resistant. 3. The Life Safety Code Standard has been reviewed and the Maintenance Director has been re-educated. A Preventative Maintenance form has been implemented (See Attachment A) 4. The Maintenance Director will complete the Preventative Maintenance form to ensure the facility remains in compliance. The form will be completed on scheduled work days as follows: daily x 2 weeks, weekly x 2 weeks, then monthly thereafter. The results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly. 5. The above corrective actions will be</p>	02/17/2012			

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	would not latch into their frames and were not smoke resistant..  3.1-19(b)		completed on or before February 17, 2012.		

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K0064 SS=E	<p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 2/02/12 at 1:38 p.m. with the Maintenance Supervisor,</p>	K0064	<p>1. No residents were affected by the alleged deficient finding. 2. All residents have the potential to be affected. A placard has been placed with the K class portable fire extinguisher next to the kitchen entry door. 3. The Life Safety Code Standard has been reviewed and the Maintenance Director has been re-educated. A Preventative Maintenance form has been implemented (See Attachment B) 4. The Maintenance Director will complete the Preventative Maintenance form to ensure the facility remains in compliance. The form will be completed on scheduled work days as follows: daily x 2 weeks, weekly x 2 weeks, then monthly thereafter. The results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted accordingly. 5. The above corrective actions will be completed on or before February 17, 2012.</p>	02/17/2012	

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	<p>there was a K class extinguisher conspicuously placed next to the entry door to the kitchen, but it lacked a placard. Based on interview on 2/02/12 at 1:40 p.m. with the Maintenance Supervisor, it was acknowledged the K class portable fire extinguisher was not provided with a placard.</p> <p>3.1-19(b)</p>			