

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2014
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NAME OF PROVIDER OR SUPPLIER  WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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K010000	<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: 04/24/14</p> <p>Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Willow Crossing Health &amp; Rehabilitation 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 V (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 hard wired smoke detectors in</p>	K010000	<p>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 survey 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 requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	

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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K010018 SS=E	<p>resident sleeping rooms. The facility has a capacity of 76 and had a census of 62 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services are sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/01/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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 1¼ 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</p>						

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K010066 SS=E	<p>permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 sets of double leaf corridor doors could latch independently into their door frames. This deficient practice could affect 6 residents observed in the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/24/14 at 1:00 p.m. with the Maintenance Supervisor, the set of double leaf corridor doors leading into the Main dining room on Main hall required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. Based on interview on 04/24/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor, the aforementioned set of corridor doors would not latch independently into their door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p>	K010018	<p>K 018 Requires door to close and latch appropriately to resist the passage of smoke.1. The double leaf corridor door leading to the Main Dining Room has been repaired so that each door will latch independently into the door frame. 2. All residents, staff and visitors utilizing the Main Dining Room have the potential to be affected. All corridor doors were inspected by the Maintenance Director to ensure proper latching occurred. 3. The inspection of all corridor doors will be completed and documented per the preventative maintenance schedule and repairs completed, as warranted. 4. The preventative maintenance log will be reviewed during the quarterly quality assurance meetings with adjustments to the audits made, as warranted. 5. The above corrective actions will be complete on or before May 24, 2014.</p>	05/24/2014			

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	<p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts in 1 of 3 areas where smoking was permitted were disposed of in a noncombustible container per facility policy. This deficient practice could affect 5 residents observed smoking in the Gazebo outside and adjacent to Activities room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/24/14 at 1:15 p.m. with the Maintenance Supervisor, one hundred extinguished cigarette butts were observed deposited in a metal container with paper waste where</p>	K010066	K066 Requires extinguished smoking materials to be disposed of in a non-combustible container.1. All paper waste has been removed from the container and a sign posted indicating no trash be placed in the container. 2. All residents, staff and visitors who utilize the gazebo smoking area have the potential to be affected. All designated smoking areas have been inspected to ensure no paper waste existed in the container. 3. Staff and resident smokers were educated on proper disposal of trash and extinguished smoking materials into the appropriate disposal containers. The regular inspection of all designated smoking areas will be addressed on the facility preventative	05/24/2014

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K010144 SS=F	<p>smoking is permitted outside in the Gazebo. Based on review of the smoking policy on 04/24/14 at 3:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts into a metal container. Based on interview on 04/24/14 at 1:17 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees allowed the disposal of cigarette butts into a metal container which is also used for the disposal of paper goods.</p> <p>3.1-19(b)</p> <p>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</p>	K010144	<p>maintenance log. 4. The ongoing audits will be reviewed during the facility's quarterly quality assurance meeting and the plan will be adjusted accordingly, as warranted. 5. The above corrective actions will be complete on or before May 24, 2014</p> <p>K144 Requires the generator to be tested unload on a monthly basis.1. The generator has been tested under load and verified to be operating at at least 30 percent of the EPS nameplate rating. 2. All residents residing in the facility have the potential to be affected. The load test was appropriately documented in the facility preventative maintenance log. 3. The Maintenance Director was educated on the appropriate</p>	05/24/2014

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	<p>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:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 04/24/14 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load was documented but they could not verify it to be 30 percent of the EPS nameplate rating for the past twelve months. Based on interview on 04/24/14 concurrent with record review with the Maintenance Supervisor, it was</p>		<p>documentation of the generator load test. 4. The generator load test will continue to be documented on the facility preventative maintenance log and will be reviewed during the quarterly quality assurance meeting to ensure continued compliance. 5. The above corrective action will be completed on or before May 24, 2014.</p>	

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K010147 SS=E	<p>acknowledged the facility had been running the generator and recording the amperage, but were unaware it had to be at least 30 percent. No other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes observed containing electrical wiring was contained in the junction box with a cover. NFPA 70, National Electrical Code, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 6 residents in the Main dining room on Main hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/24/14 at 2:15</p>	K010147	<p>K147 Requires that electrical wiring be contained within a junction box with a cover. 1. The electrical wiring in the junction box adjacent to the Main Dining Room has been properly covered. 2. All residents staff and visitors utilizing the Main Dining Room have the potential to be affected. All other electrical junction boxes have been inspected by the facility Maintenance Director to ensure wiring is properly contained within the junction box 3. The Maintenance Director was educated on ensuring all electrical wiring is properly contained within the junction box following any electrical work. 4. The weekly monitoring of the electrical junction boxes will be</p>	05/24/2014

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	<p>p.m. with the Maintenance Supervisor, a total of four electrical wires were jutting out of an uncovered electrical junction box above the smoke wall adjacent to the Main dining room. Based on interview on 04/24/14 at 2:17 p.m. it was acknowledged by the Maintenance Supervisor, the electrical wires jutting out of the electrical junction box were not protected with a cover.</p> <p>3.1-19(b)</p>		<p>added to the facility preventative maintenance log. The logs will be reviewed at the quarterly quality assurance meeting to ensure continued compliance. 5. The above corrective action will be completed on or before May 24, 2014.</p>	