STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 01 / B. WING	07/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

(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
K 0000 Bldg. 01	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: 07/05/16 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this Life Safety Code survey, Woodland Manor 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 corridor and areas open to the corridor and battery operated smoke detectors in the resident rooms. The facility has a capacity of 80 and had a census of 57 at the time of this survey.	K 0000		

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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	Quality Review completed on 07/08/16 - DA			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 1. Based on observation and interview, the facility failed to ensure 1 of 1 Activity room and 1 of 48 resident room corridor door did not have an impediment to latching. This deficient practice could affect staff and up to 60 residents. Findings include: Based on observation with the Maintenance Director on 07/05/16 at	K 0018	K18 Element One: All resident door and doors to common roomswill close without impediment to not affect proper smoke compartment Element Two: Allresident room doors and common room doors were corrected to ensure properclosure. Element Three: Staffwas educated on the need to ensure proper closure of Resident room	08/01/2016

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	10:39 a.m. then again at 10:59 a.m., a bed impeded the corridor door resident room 113 from closing and latching into the door frame. Then again, the Activity room corridor door got caught up on a rug when attempting to close the door. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 48 resident room corridor door would resist the passage of smoke. This deficient practice could affect staff and up to 24 residents. Findings include: Based on observation with the Maintenance Director on 07/05/16 at 11:59 a.m., resident room 311 corridor door contained a quarter inch penetration above the door handle. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		doors andcommon room doors. Element Four: Maintenance Supervisor and or designee ill audit door closure 3 timesper week for 4 weeks, then weekly for 4weeks. If audit shows 100% complianceaudit will be discontinued. All findingswill be reviewed in Quality Assurance meeting any negative outcomes will resultin continued audit Compliance Date August 1, 2016	
K 0029	NFPA 101			

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SS=E Bldg. 01	LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 hazardous areas were provided with a self-closer and would latch into the frame. This deficient practice could affect staff and up to 14 residents. Findings include: Based on observation with the Maintenance Director on 07/05/16 between 10:59 a.m. and 11:39 a.m., the following was discovered: a) oil based popcorn maker in Activities. The 1 of 1 corridor door did not have a self-closing device installed b) fifty large cardboard boxes filled with medical record files in the Medical Records office. The 1 of 1 corridor door did not have a self-closing device installed. c) 1 of 2 Kitchen doors caught on the floor and failed to fully self-close. d) 1 of 2 Dish room open to the Kitchen	K 0029	K029 Element One: Thefacility doors will have appropriateself- closing devices to ensure proper closure of doors and fully close andlatch into frame Element Two: Allaffected doors will have appropriate closures installed or be replace to ensureproper closure and latching. Element Three: Staff was educated on the need to ensureproper closure of Resident room doors and common room doors. Element Four: Maintenance Supervisor and or designee ill audit door closure 3 timesper week for 4 weeks, then weekly for 4weeks. If audit shows 100% complianceaudit will be discontinued. All findingswill be reviewed in Quality Assurance meeting any negative outcomes	08/01/2016

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	failed to latch into the frame. Additionally, 1 of 2 Dish room open to the Kitchen corridor doors did not have a self-closing device installed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		will resultin continued audit Compliance Date August 1, 2016	
K 0048 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 1. Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect staff and up to 60 residents.	K 0048	K48 Element One: 1.Facility will maintain an fire policy correctly indicating smoke compartments.2. Fire plan will indicated the relocation of wheeled equipment during aemergency. Element Two: Facilityfire plan will be updated to reflect proper smoke compartments and wheeledequipment storage. Element Three: Staffwill be educated on fire policy plan. Element Four: Maintenance Supervisor and or designee will audit staff to ensureknowledge of policy 1 time weekly with random audit for six weeks , then monthythereafter. If audit shows	08/01/2016

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	Findings include: Based on a record review with the Maintenance Director on 07/05/16 at 12:22 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a smoke barrier. However, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on interview at each observation, there were three sets of doors that the Maintenance Director acknowledged and confirmed were not complete smoke or fire barriers. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide a written plan that addressed relocation of wheeled equipment during an emergency. NFPA 101 19.2.3.4(4)(b) requires health care occupancies have a safety plan and training program. This deficient practice could affect staff and up to 24 residents. Findings include: Based on a record review with the		100% compliance audit will be discontinued. All findings will be reviewed in QualityAssurance meeting any negative outcomes will result in continued audit Compliance Date August 1, 2016	

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	Maintenance Director on 07/05/16, the facility had a written fire policy. The policy did not include response to items stored in the corridor. Based on observation at 10:38 a.m., a wheelchair was stored in the corridor outside of resident room 113. Based on interview at observation, the Maintenance Director the aforementioned condition. 3.1-19(b)			
K 0062 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 resident room 229 sprinkler head in the facility was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to	K 0062	K62 Element One: Allsprinkler heads will be maintained in proper working order and be unobstructed. Element Two: All sprinklerHeads will be audited for obstruction and proper condition, free of paint toensure proper function. Element Three: Staffwill be educated on maintain proper sprinkler head clearance to ensure properfunction of sprinkler system. Element Four: Maintenance Supervisor and or designee willaudit all sprinkler heads 2	08/01/2016

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	ensure adequate coverage of the hazard. This deficient practice could affect staff and up to 2 residents. Findings include: Based on observation with the Maintenance Director on 07/05/16 at 10:43 a.m., resident room 229 sidewall sprinkler head was covered with the room's separation curtain. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 2 of 12 Kitchen sprinkler heads. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only. Findings include:		times per for weeks, and then monthly thereafterfor proper clearance and paint. If audit shows 100% compliance audit will bediscontinued. All findings will bereviewed in Quality Assurance meeting any negative outcomes will result incontinued audit Compliance Date August 1, 2016	

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	Based on observation with the Maintenance Director on 07/05/16 at 11:37 a.m., two sprinkler heads were covered in paint in the Kitchen. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0066 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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 Based on observation and interview, the facility failed to ensure 2 of 2 areas where smoking was permitted for staff and	K 0066	K66 Element One: Thefacility will ensure that proper smoking	08/01/2016

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	residents was maintained. This deficient practice could affect staff and up to 3 residents. Findings include: Based on observations with the Maintenance Director on 07/05/16 at 10:54 a.m. then again at 11:25 a.m., there were at least 25 cigarette butts on the ground in the designated resident smoking area. Then again, there were at least 30 cigarette butts on the ground in the designated staff smoking area. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		containers are provided in designatedsmoking areas. Element Two: Additional cigarette receptacles will be placein designated smoking areas to ensure proper disposable of cigarettes. Element Three: Staffand Resident will be educated on proper disposal and use of receptacles indesignated smoking areas. Element Four: Maintenance Supervisor and or designee will audit smoking areas 3 timesper week for four weeks then weekly for 4 weeks. If audit shows 100% complianceaudit will be discontinued. All findingswill be reviewed in Quality Assurance meeting any negative outcomes will resultin continued audit Compliance Date August 1, 2016	
K 0144 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) 1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 110, The Standard for Emergency and	K 0144	K144 Element One: The facility shall maintain appropriategenerator load logs to ensure proper	08/01/2016

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	Standby Power Systems, Section 6-4.2.2 requires Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all staff, residents, and visitors. Findings include: Based on record review with the Maintenance Director on 07/05/16 at 9:47 a.m., none of the last twelve months of generator load testing could reach 30 percent. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed that the last load bank test was performed on 01/15/15. 3-1.19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall		function of generator. Element Two: Thefacility will have the generator load tested by a qualified vendor to show thatthe generator is operating properly and that proper switching, cool down , andload are maintained. Element Three: Maintenance Supervisor willeducated to maintain appropriategenerator records . Element Four: Administrator and or designeewill audit generator maintenance logs monthly for six months, If audit shows100% compliance audit will be discontinued. All findings will be reviewed in Quality Assurance meeting any negativeoutcomes will result in continued audit Compliance Date August 1, 2016	

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	be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors. Findings include: Based on record review with the Maintenance Director on 07/05/16 at 9:47 a.m., the monthly testing forms failed to include the transfer time for twelve months of the last twelve months of testing. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3-1.19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the			

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	Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review with the Maintenance Director on 07/05/16 at 9:47 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment	K 0147	K147 Element One: TheFacility will ensure that all electrical equipment is plug into	08/01/2016

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	with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation with Maintenance Director on 07/05/16 at 11:43 a.m., a surge protector was powering a refrigerator and a coffee pot in the Maintenance office. Additionally, a surge protector was powering another surge protector powering phone equipment. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		properelectrical outlets. Element Two: Allimproperly plug devices or equipment have been corrected and plugged intoappropriate outlets. Element Three: Allstaff will be educated on the proper connection of electrical equipment toensure compliance. Element Four: Maintenance Supervisor and or designee will conduct audits 2 timesweekly for four weeks and weekly thereafter of all electrical equipment, If audit shows 100% compliance audit will bediscontinued. All findings will bereviewed in Quality Assurance meeting any negative outcomes will result incontinued audit Compliance Date August 1, 2016	