

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155726	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  03/28/2013
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NAME OF PROVIDER OR SUPPLIER  WOODLANDS AT RIVER TERRACE ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 CAYLOR BLVD BLUFFTON, IN 46714
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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: 03/28/13</p> <p>Facility Number: 003575 Provider Number: 155726 AIM Number: 200395060</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Woodlands at River Terrace Estates 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, areas open to the corridors and hard wired smoke detectors in the resident</p>	K010000	The submission of this plan ofCorrection does not constituteas admission by the provider ofany fact or conclusion set forthin this statement of deficiency.This plan of correction isSubmitted because the law requires it.	
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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>rooms. The facility has a capacity of 30 and had a census of 28 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has a maintenance building providing facility services including maintenance supplies that was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 3 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 says doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 says door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect at least 15 residents in the dining room near the health care entrance.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 03/28/13 at 2:17 p.m., the main entrance/exit door was magnetically locked and could be opened by entering a code, but the code was not posted. Based on an interview with the Director of Plant Operations at the time of</p>	K010038	<p><b>K038 (1.)</b> Plant Operations Director/ Designee has posted a sign with a instructions for the code above the keypad at the exit near the nurses' station. (See <u>attachment A</u>) <b>(2.)</b> 15 Residents near the dining area could be affected by the deficient practice. <b>(3.)</b> An in-service was conducted with all staff on the new entry keypad requirements and use of the instructions on sign. (See <u>attachment AA</u>) <b>(4.)</b> Plant Operations Director/ Designee will monitor monthly to assure the sign is posted. The results will be reported to the QA Committee. (See <u>attachment B</u>) <b>(5.)</b> Date of compliance April 10, 2013</p>	04/10/2013
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	<p>observation, he thought the sign above the keypad stating "Please see nurse for door code" was sufficient.</p> <p>3.1-19(b)</p>				

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Monthly Fire Drill Activation Form" with the Director of Plant Operations on 03/28/13 at 1:23 p.m., there was no record of a second shift fire drill for the third quarter of 2012. Based on an interview with the Director of Plant Operations at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p><b>K050 (1.)</b> Plant Operations Director/ Designee has implemented anew Fire drill schedule with specific Times stated for each shift for each month. <u>(See attachment C)</u> <b>(2.)</b> All residents have the potential to be affected by the deficient practice. <b>(3.)</b> An in-service was conducted with maintenance staff on new monthly fire drill procedures. <u>(See attachment D)</u> <b>(4.)</b> Plant Operations Director/ Designee will monitor on an ongoing basis to assure that monthly fire drills are conducted on time. The results will be reported to the QA Committee. <u>(See attachment E)</u> <b>(5.)</b> Date of compliance April 10, 2013</p>	04/10/2013			

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K010064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 1 K Class 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 was not in a resident care area but could affect the kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Operations on 03/28/13 at 2:50</p>	K010064	<p><b>K064 (1.)</b> Plant Operations Director/ Designee has installed a placard sign over the top of the K class fire extinguisher in the kitchen stating it is a secondary unit to be used only after hood system is activated. (See attachment F) (2.) All residents have the potential to be affected by the deficient practice. (3.) An in-service was conducted with all kitchen staff on use of K class fire extinguisher and hood system. (See attachment G) (4.) Plant Operations Director/ Designee will monitor that placard is in place monthly. The results will be reported to the QA Committee. (See attachment H) (5.) Date of compliance April 10, 2013</p>	04/10/2013			

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	<p>p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Director of Plant Operations at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p>			