

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2013
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918
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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: 06/26/13</p> <p>Facility Number: 000323 Provider Number: 155778 AIM Number: 100288440</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Woodland Manor Nursing 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 III (211) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors. Resident rooms are equipped with battery powered</p>	K010000	The creation and submission of this plan of correction does not constitute and admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible allegation of compliance on or after 7/19/2013. Fay Pruitt, HFA	
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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>smoke detectors. The facility has a capacity for 52 and had a census of 43 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. A detached garage used for maintenance equipment storage was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/08/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>						

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K010018 SS=F	<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 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. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 4 of 6 smoke compartments were provided with positive latches suitable to the authority having jurisdiction to hold the doors securely in the door frame. LSC 19.3.6.3.2 requires corridor doors be provided with a means suitable for keeping the doors closed that is acceptable to the authority having jurisdiction. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 06/26/13 between 1:00 p.m. and 3:40 p.m., double</p>	K010018	<p>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice? A) Magnets have been tested to ensure the doors remain closed if five pounds of pressure is applied. B) C116 Latches have been removed and replaced with magnets that remain closed if five pounds of pressure has been applied. C) Double doors to chapel and activities office slide bolt has been replaced with an automatic latch at the top of the door. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all resident room doors to ensure that door remains closed with five pounds of applied</p>	07/26/2013

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	<p>doors providing access to rooms 101, 102 and 103 on A hall; 104, 105, 106, 108, 109, 110 and 111 on B hall; 112, 113, 114, 115, 117, 118, and 119 on C hall; and rooms 120 to 127 on D hall were each equipped with magnets to secure the doors to their door frames. The magnets securing the doors required varied pressures to open them. There was no means to ensure the doors remain closed if five pounds of pressure was applied to the latch edge of the doors to open them. The maintenance director said at the time of observations, additional magnets had been applied to the doors and frames when they did not hold the doors closed. He said he did not know how much force it took to open each door.</p> <p>b. Based on observation with the maintenance director on 06/26/13 at 1:30 p.m., the double doors to room C116 had been modified with pegs at the top of each door and latches into which they would secure at the top of the door frame. Then a roller latch would engage to secure the doors together. However when tested at the time of observation, the doors could be pushed open. The maintenance director acknowledged at the time of observations, the latches did not reliably hold the doors securely in the door frame.</p> <p>c. Based on observation with the maintenance director on 06/26/13</p>		<p>pressure. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct and document monthly checks to ensure all doors close properly and remain closed with five pounds of pressure applied. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report any issues to the Quality Assurance committee. The Q. A. committee shall review and provide suggestions if necessary. Compliance justification by FSES evaluation. Completion date: 7/26/13</p>				

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	<p>between 12:45 p.m. and 1:00 p.m., double door sets to the chapel and activities office each had one door with a slide bolt which had to be latched into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The maintenance director acknowledged at the time of observations, each door could not positively latch automatically into the door frame.</p> <p>3.1-19(b)</p>			

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure ceiling and wall smoke barrier penetrations in 2 of 6 sprinklered smoke compartments were sealed in a manner which maintains the one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.2 requires smoke barriers to be continuous from floor to ceiling and outside wall to outside wall. This deficient could affect visitors, staff and 10 or more residents in spaces adjacent to the kitchen, laundry and maintenance shop.</p> <p>Findings include:</p>	K010025	<p>What corrective action(s) will be accomplished for those resident s found to have been affected by the deficient practice: A) Unsealed area around pipes in the kitchen janitors closet and kitchen storage rooms had fire caulking installed.B) The 24 by 24 inch attic fan has been repaired and is functioning properly. C) Six unsealed ceiling conduit penetrations gaps had fire caulking installed. D) Foam has been replaced with fire caulking. E) Unsealed areas and expandable foam replaced with fire caulking. How other residents having the potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken: The maintenance director and HFA shall examine all areas the building to ensure all areas/gaps are sealed properly to smoke penetrations. What measures will be put into place or what systemic changes will be made to ensure</p>	07/19/2013

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	<p>Based on observation with the maintenance director between 1:00 p.m. and 3:40 p.m., ceiling and wall penetrations were found:</p> <ul style="list-style-type: none"> a. Unsealed around pipes in the kitchen janitors closet and kitchen storage rooms leaving gaps of one half to one inch into interstitial spaces in the walls and into the attic above; b. In the kitchen ceiling where a 24 by 24 inch attic fan reported by the maintenance director and a kitchen aide as not functioning had fan louvers which were bent and not tightly closed leaving openings of one inch along the length of the louvers into the attic above; c. Six unsealed ceiling conduit penetrations in the sprinkler riser room which left half inch gaps into the attic; d. In the maintenance electrical switch room in the ceiling sealed with expandable foam; e. Around conduit in the laundry, either unsealed or sealed with expandable foam. In addition pipe insulation was relied upon to seal around pipes penetrating the walls. <p>The maintenance director acknowledged the materials in use to seal penetrations at the time of observations and said he thought the foam was good for preventing the passage of smoke.</p>		<p>that the deficient practice does not recur: The maintenance director shall conduct monthly rounds to ensure areas are sealed properly to prevent smoke penetrations. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The maintenance director shall report to Quality Assurance committee. The Q. A. Committee shall review report and provide suggestions if necessary. Completion date: 7/19/2013</p>	

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K010029 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 hazardous areas, such as the kitchen, was separated from adjacent spaces by a door which closed and latched automatically, or upon activation of the fire alarm system. Doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This practice affects visitors, staff and and 10 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/26/13 at 1:50 p.m., the four by five foot kitchen food service window in the corridor wall had a wooden door which slid on a track mounted to the exterior of the kitchen wall. The door could be opened and closed automatically if it was attached to</p>	K010029	<p>What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: The four by five foot kitchen door has been corrected with roller guides/latch to ensure proper closure. How other resident having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: All smoke doors shall be inspected by the maintenance director and HFA to ensure proper closure of all fire/smoke doors. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director shall conduct monthly checks/drills to ensure proper closure of all doors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be</p>	07/19/2013			

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	a magnet which was magnetized and held the door open. At the time of observation the magnet was deenergized and the door had been manually closed. The bottom of the door was moving away from the wall at intervals, presumably due to fans and air currents in the adjoining spaces. The maintenance director said at the time of observation, the bottom of the door should have slid behind a hand rail attached to the wall where the door closed the opening. Instead, it rested on the outside of the rail leaving a one inch gap along the four foot opening. He said staff had not closed it properly when they manually closed the door after deenergizing the hold open magnet with a toggle switch he had applied for the purpose. He said when the door was held open by the magnet and the fire alarm sounded, it would side into the space between the rail and wall to restrict the passage of smoke. He was asked to demonstrate the function on 06/26/13 at 2:00 p.m. He opened the door manually, flipped a toggle switch and attached the door to the energized magnet. The fire alarm was activated. The door closed, hit the end of the hand rail and left a half inch gap along the edge between the door and opening to the kitchen. The maintenance director acknowledged at the time of observation, the door had not self closed and latched and could not always		put into place: The maintenance director shall report any issues to Quality Assurance Committee. Q. A. committee shall review and provide suggestions as necessary. Completion date: 7/19/2013				

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	do so if the magnet were deenergized when the door was open. 3.1-19(b)				

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K010038 SS=D	<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 13 of 19 ground floor resident room exit doors were provided with door knobs readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect visitors, staff and 2 residents in room E107.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/26/13 at 1:55 p.m., the door opening for resident rooms was 46 inches wide with two, 24 inch double doors providing access to the corridor. The means of latching the double door set to resident room E107 had one door in the door set provided</p>	K010038	What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: Top latch has been replace with magnetic closure that have been tested to ensure the doors will remain closed if five pound of applied pressure. Compliance justification by FSES evaluation. (FSES evaluation to be submitted by FP&C consultants)	07/26/2013			

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	<p>with an automatic latch at the top of the door which would secure it into the door frame. Then the door knob latch, when secured into the latch stile, could hold the doors securely in place. In order to open the doors, the top latch could be opened by pulling the end of a chain which hung ten to twelve inches from the top of one door and the door knob had to then be turned to open the doors. The maintenance director agreed at the time of observation, the arrangement was difficult, if not impossible for residents to open their own door if they were wheelchair bound, short in stature and unable to reach the chain for the top latch, or confused.</p> <p>3.1-19(b)</p>			

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K010040 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5</p> <p>Based on observation and interview, the facility failed to ensure resident exit access doors in 1 of 6 smoke compartments allowed a clear width of at least 32 inches. This deficient practice affects visitors, staff and two residents in room E107.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/26/13 at 1:55 p.m., the door opening for resident rooms was 46 inches with two 24 inch double doors providing access to the corridor. The means of latching the double door set to resident room E107 had been modified to provide one door in the door set an automatic latch at the top of the door which would secure it into the door frame. The door knob latch, when secured into the latch stile of the second door, could hold the doors securely in place, however, this arrangement allowed only one door to open at a time for exit access which resulted in a 24 inch opening for the residents, wheelchair bound or not, to access the exit corridor. The maintenance director acknowledged</p>	K010040	What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice: Door latches have been replace with magnetic closure that have been tested to ensure the doors remain closed if five pounds of pressure is applied. Compliance justification by FSES evaluation. (FSES evaluation to be submitted by FP&C consultants)	07/26/2013

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	at the time of observation, the opening did not provide the minimum 32 inch opening. 3.1-19(b)				