

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2015
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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
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K 000 Bldg. 01	<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: 03/16/15</p> <p>Facility Number: 000064 Provider Number: 155139 AIM Number: 100288770</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, North Woods Village 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 two story facility was determined to be of Type II (000) 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 resident rooms have</p>	K 000	<p>March 25, 2015</p> <p>Ms. Kim Rhoades, Director Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204</p> <p>Dear Ms. Rhoades:</p> <p>Please accept this 2567 Plan of Correction for the LifeSafety Code Survey ending March 16, 2015as our Letter of Credible Allegation. Wealso respectfully request Desk Review in lieu of a post survey revisit on orafter March 31, 2015</p> <p>Thank you for your time in reviewing our plan of correctionand please call with any questions.</p> <p>Sincerely,</p> <p>Cathy S. Greene Executive Director North Woods Village</p>	
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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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K 066 SS=E Bldg. 01	<p>battery powered smoke detection. The facility has a capacity of 164 and had a census of 154 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered except for the two detached garages for facility storage and a shed which were not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/20/15.</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 Smoking regulations are adopted and include no less than the following provisions:</p> <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</p>						

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	<p>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 Based on observation, record review and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 1 areas where smoking was permitted. This deficient practice could affect 32 residents on 100 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/16/15 at 2:25 p.m. with the Maintenance Supervisor, at least one hundred cigarette butts were observed deposited on the ground outside the dining room exit which is not in a designated smoking area. Based on review of the smoking policy on 03/16/15 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 and provided where the designated smoking area was located. Based on interview on 03/16/15 concurrent with the observation with the Maintenance Supervisor it was acknowledged the facility's employees were throwing their cigarette butts on the</p>	K 066	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any; conclusion set forth in the statement of deficiencies or of any violation of regulation.</p> <p>This provider respectfully request that the 2567 plan of correction be considered the letter of credible allegation and respectfully request desk review in lieu of a Post Survey Review on or after 3-31-15.</p>	03/31/2015

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	ground in an area where smoking was not allowed. 3.1-19(b)		<p>K066</p> <p>It is the practice of this provider to ensure that the smoking policy is followed to meet LSC requirements.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice. *Cigarette butts were cleaned up by Housekeeping staff on 3-17-15 and staff re-educated on smoking policy and proper disposal of cigarette butts in appropriate metal containers to meet the LSC requirement on 3-17-15 and 3-24-15 by Staff Development Coordinator (SDC).</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice. *Cigarette butts were cleaned up by Housekeeping staff on 3-17-15 and staff re-educated on smoking policy and proper disposal of cigarette butts in appropriate metal containers to meet the LSC requirement on 3-17-15 and 3-24-15 by Staff Development Coordinator (SDC).</p>	

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			<p>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?</p> <p>*Housekeeping staff will monitor all entry ways to facility for inappropriate discarded cigarette butts daily and will clean up immediately.</p> <p>*Reviewed other potential areas and these areas have been cleaned of cigarette butts to meet LSC standards on 3-17-15 and daily by Housekeeping staff.</p> <p>* staff re-educated on smoking policy and proper disposal of cigarette butts in appropriate metal containers to meet the LSC requirement on 3-17-15 and 3-24-15 by Staff Development Coordinator (SDC)</p> <p>*Disciplinary action will result for any employee not following the proper disposal of cigarette butts.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>*Daily observation for inappropriate disposition of cigarette butts by Housekeeping staff and weekly by Housekeeping supervisor and CQI "Environmental Safety Review" tool will be used weekly x 4, monthly x 6 and quarterly up to 6 months to monitor so deficient practice does not recur by Housekeeping supervisor.</p> <p>*Housekeeping supervisor is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 3-31-15</p>	

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K 070 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in non resident rooms. This deficient practice could affect any resident on Administrative hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 03/16/15 at 1:25 p.m. with the Maintenance Supervisor, one portable space heater was plugged in and running in the Admissions office adjacent to the Administrative hall. Based on interview on 03/16/15 concurrent with the observation, it was acknowledged by the Maintenance Supervisor the space heater was not allowed in the facility which was in accordance with the space heater policy reviewed at 3:35 p.m.</p> <p>3.1-19(b)</p>	K 070	<p>K070It is the practice of this provider to ensure that portable space heating devices are not used in the facility.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice. *The space heater was removed immediately on 3-16-15 by Executive Director. *Staff was inserviced on not using space heaters in the facility on 3-16-15 and again on 3-24-15 by Staff Development Coordinator(SDC) or designee.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>*All residents have the potential to be affected by the alleged deficient practice. *All other offices in facility were assessed for space heaters on 3-16-15 and none were found by Executive Director. * The space heater was removed immediately on 3-16-15 by Executive Director. * Staff was inserviced on not using space heaters in the facility on 3-16-15 and</p>	03/31/2015

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			<p>again on 3-24-15 by Staff Development Coordinator(SDC) or designee.</p> <p>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?</p> <p>*Any further infractions in the use of portable space heaters will result in disciplinary action.</p> <p>* Staff was inserviced on not using space heaters in the facility on 3-16-15 and again on 3-24-15 by Staff Development Coordinator(SDC) or designee.</p> <p>* Housekeeping will monitor with daily during office cleaning schedule and on daily rounds of facility. To ensure no portable space heaters are being used.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>*Daily room cleaning and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 6 and quarterly up to 6 months to monitor so deficient practice does not recur.</p> <p>*Housekeeping supervisor is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 3-31-15.</p>	