STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 01 / B. WING	10/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591

(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: 10/04/16 Facility Number: 000016 Provider Number: 155042 AIM Number: 100291500 At this Life Safety Code survey, Willow 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 with a lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 170 and had a census of 99 at the time of this survey.	K 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective November 3, 2016 the annual licensure survey conducted on October 7, 2016 through October 7, 2016.	

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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	All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, an enclosed metal carport used for storage of landscaping equipment, and a wood minibarn used for storage of biohazardous waste. Quality Review completed on 10/06/16 - DA			
K 0015 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to ensure 1 of 17 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A, Class B or Class C for a sprinklered facility. LSC 3.3.112 defines interior finish as the exposed surfaces of walls, ceilings and floors. A.3.3.112 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect mostly staff in the laundry	K 0015	**K 015** **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The 15 foot section of exposed studs and two by fours on the interior wall separating the dryer room from the	11/03/2016

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	room. Findings include: Based on observation on 10/04/16 at 11:30 a.m. during a tour of the facility with the Maintenance Director, there was a 15 foot section of exposed wood studs and two by fours on the interior of the wall separating the dryer room from the rest of the laundry room. This was acknowledged by the Maintenance Director at the time of observation, furthermore, the Maintenance Director said the exposed wood studs and two by fours did not have a flame spread rating. 3.1-19(b)		rest of the laundry room have been covered. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The deficient practice could affect mostly staff in the laundry room per the Inspection Report. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** New Construction/Re-model has been added to the monthly PM Log. This will remind Maintenance staff to inspect areas that have recently been constructed or have had a re-model. **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:**	

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			Monthly PM Log will be used to monitor this type of issue. Maintenance will bring the logs to QA meeting monthly. **By what date the systemic changes will be completed:** 11/3/2016	
K 0018 SS=B 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 Based on observation and interview, the facility failed to ensure 5 of 10 sets of double doors to the corridor were equipped with positive latches and latched into the door frame automatically.	K 0018	**K 018** **What Corrective action(s) will be**	11/03/2016

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	This deficient practice could affect 51 residents, as well as staff and visitors in the D, E, and F Wings. Findings include: Based on observations on 10/04/16 between 11:15 a.m. and 2:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. Two sets of double doors to the two closets in the D wing Sitting Area, which was open to the corridor, did not positive latch into their door frames. b. Two sets of closet double doors to the corridor in the E wing did not positive latch into their door frames. c. One set of closet double doors to the corridor in the F wing did not positive latch into their door frame. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice:** Two sets of double doors to the two closets in the D wing sitting area have been repaired and latch into their door frames. Two sets of closet double doors to the corridor in the E wing were repaired and latch into their door frame. One set of closet double doors to the corridor in F wing were repaired and latch into their door frame. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The inspection was of the entire facility, doors not latching have been repaired. The doors identified have been added to monthly PM Log. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The doors that had to be repaired	

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			have been added to the monthly PM Log. This will ensure they are on scheduled check for proper functioning. Maintenance Staff will educate Department employees to utilize Work Orders if they find latches that need repaired. **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:** Work Orders will be used to identify non-latching doors. Door latches will be monitored monthly by our Maintenance Staff. Monthly PM Logs will be submitted to the Quality Assurance team quarterly and will be ongoing. **By what date the systemic changes will be completed:** 11/3/2016	
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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.			

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	Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 1. Based on record review and interview, the facility failed to ensure each documented fire drill included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department for 1 of 12 fire drills. LSC 19.7.1.2 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 10/04/16 at 9:45 a.m. with the Maintenance Director present, a fire drill performed during the third shift on 6/22/16 did not include information that the monitoring company/fire department was called to verify the transmission of the fire alarm was received. Based on interview at the time of record review, this was acknowledged by the Maintenance Director. 3-1.19(b)	K 0050	**K 050** **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Fire Drills have been and will continue to be completed monthly per Willow Manor Policy. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Fire Drills are for the entire facility and affect all residents. Fire Drills will have been and will continue to be completed monthly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	11/03/2016

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	2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 10/04/16 at 9:45 a.m. with the Maintenance Director present, three of four, first shift (day) fire drills were performed between 1:23 p.m. and 1:57 p.m., furthermore, the fire drill performed during the first shift on 7/14/16 did not have a time of drill listed. During an interview at the time of record review, the Maintenance Director acknowledged the times the first shift fire drills were performed and agreed the times were not varied enough, and the time of the 7/14/16 fire drill was not included. 3-1.19(b)		Administrator conducted in-service with Maintenance Supervisor on completion of Fire Drill. Emphasis was placed on ensuring the time of the drill was listed. A new schedule has been created that includes the date and time. This schedule will ensure the times are varied. **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:** Administrator will review and "sign off" on monthly Fire Drill to ensure proper completion of the Drill. Fire Drill audits will be presented to Quality Assurance Team monthly. **By what date the systemic changes will be completed:** 11/3/2016	
K 0062 SS=E 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 Based on observation and interview, the	K 0062	**K 062**	11/03/2016

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	facility failed to ensure 3 of over 1000 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect 6 residents, as well as staff and visitors in the G, H, and I wings if required to exit to the outside. Findings include: Based on observations on 10/04/16 between 11:15 a.m. and 2:00 p.m. during a tour of the facility with Maintenance Director, one sprinkler head outside each of the G, H, and I exits, under each overhang, was covered with corrosion. This was acknowledged by the Maintenance Director at the time of each observation. 3.1-19(b)		**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The three sprinkler heads have been replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Our Sprinkler Head/System Vendor is SafeCare. They will conduct an Audit of all Sprinkler heads and repair any other heads found to be corroded or faulty. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Sprinkler Head "checks" have been added to the monthly PM inspection log. Maintenance has obtained spare heads and replace them as	

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			needed. **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:** Corporate Property Manager will conduct Quarterly inspection of the building, to include sprinkler head check. PM Logs will be submitted to Quality Assurance Team monthly. **By what date the systemic changes will be completed:** 11/3/2016	
K 0144 SS=C 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) Based on record review and interview, the facility failed to ensure 1 of 1 emergency generator was allowed a 5 minute cool down period after each load test, furthermore, the facility failed to provide documentation that the transfer time for the generator was being recorded	K 0144	**K 144** **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	11/03/2016

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	after each 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 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 review of the facility's Generator Monthly Test on 10/04/16 at 10:55 a.m. with the Maintenance Director present, the generator log form documented the generator was tested monthly for 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, furthermore, there was no documentation that showed the generator transfer time being recorded following its load test. During an interview at the time of record review, the Maintenance Director		A retest of the Generator has been completed that includes documentation of a 5 minute cool down time and the generator transfer time. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Maintenance PM Log for generator has been modified so the required 5 minute cool down can be recorded along with recording the generator transfer time. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The modified PM Log will be utilized from this day forward to ensure the Generator Monthly test is conducted in accordance with Standard for Emergency and Standby Power Supply.	

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	confirmed the monthly generator log did not include documentation of a cool down time being recorded or the generator transfer time being recorded. 3.1-19(b)		**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:** Corporate Property Manager will conduct Quarterly inspection of the building, to include review of Inspections. PM Logs will be submitted to Quality Assurance Team monthly. **By what date the systemic changes will be completed:** 11/3/2016	