

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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K 0000 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: 06/15/15</p> <p>Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710</p> <p>At this Life Safety Code survey, Willow Crossing Health and Rehabilitation 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 V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 59 at</p>	K 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary to confirm said compliance, feel free to contact me</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 0018 SS=A Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinkled except the main dining room and all areas providing facility services were sprinkled. The facility has one detached garage used for storage which is not sprinkled.</p> <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 the 1 of 16 Service Hall room doors was provided with a suitable means for keeping the door closed. This deficient practice affects maintenance staff who work in the Service Hall area near the transformer room.</p> <p>Findings include:</p>	K 0018	K 018 Requires the facility to ensure rooms have suitable means for keeping the door closed. 1. The service hall transformer room door had latching hardware placed and the 3 inch diameter hole in the door was repaired. 2. All staff utilizing the service hall transformer room door have the potential to be affected. All doors were inspected by the Maintenance Director to ensure proper latching	07/15/2015

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K 0025 SS=E Bldg. 01	<p>Based on observation with the maintenance supervisor on 06/15/15 at 10:10 a.m., the Service Hall transformer room door lacked latching hardware and had a three inch diameter hole in the door where the latching hardware would have been. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <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 observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 ceiling was constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier</p>	K 0025	<p>hardware is in place and no holes are present. 3. The inspection of all corridor doors will be completed and documented per the preventative maintenance schedule and repairs completed, as warranted.4. The preventative maintenance log will be reviewed during the quarterly quality assurance meetings with adjustments to the audits made, as warranted.5. The above corrective actions will be complete on or before July 15, 2015.</p> <p>K025 Requires the facility to ensure the smoke barriers in the ceiling is constructed to provide at least one half our fire resistance rating. 1. The penetrations in the transformer room ceiling, maintenance room ceiling, 100 hall ceiling and 100 hall closet ceiling were fire stopped.2. All residents residing in the facility have the potential to be affected.</p>	07/15/2015

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	<p>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. This deficient practice affects 12 residents who use 100 Hall therapy room.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the facility on 06/15/15 from 9:15 a.m. to 1:30 p.m., the following locations had ceiling penetrations not firestopped;</p> <ol style="list-style-type: none"> 1. The transformer room ceiling one, one half inch gap around a cable bundle penetration and an open three inch electrical conduit not fire stopped. 2. The maintenance office ceiling had four, one half inch gaps around cable bundle penetrations and a one inch gap around a four inch sewer pipe penetration not fire stopped. 3. The 100 Hall therapy room office ceiling had a one half inch gap around a cable bundle penetration and four, one inch circular holes not fire stopped. 4. The 100 Hall therapy room closet ceiling had a one inch gap around an electrical conduit penetration not fire stopped. <p>The transformer room ceiling, maintenance office ceiling, and 100 Hall</p>		<p>The Maintenance Director inspected the facility's ceiling to ensure all penetrations are fire stopped. 3. The Maintenance Director was educated on fire resistance rating regarding ceiling penetrations (See Attachment A)4. The inspection of the facility's ceilings ensuring all penetrations are fire stopped will continue to be documented on the facility preventative maintenance log and will be reviewed during the quarterly quality assurance meeting to ensure continued compliance.5. The above corrective action will be completed on or before July 15, 2015.</p>	

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K 0027 SS=E Bldg. 01	<p>therapy room office ceiling and closet ceiling penetrations not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 30</p>	K 0027	K027 Requires the facility to ensure smoke barrier doors can resist the movement of smoke for at least 20 minutes. 1. The 100 hall set of smoke barrier doors and the 200 hall smoke barrier doors were reset to ensure no gaps were present when the doors are in a closed position.2. All residents residing in the facility have the potential to be affected. The Maintenance Director inspected all smoke barrier set doors to ensure no gaps were present when in closed position. 3. The Maintenance	07/15/2015

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K 0029 SS=A Bldg. 01	<p>residents who reside on the 200 Hall and 29 residents who reside on the 100 Hall.</p> <p>Findings include:</p> <p>Based on observations on 06/15/15 during a tour of the facility from 9:15 a.m. to 1:30 p.m. with the maintenance supervisor, the 100 Hall set of smoke barrier doors and the 200 Hall set of smoke barrier doors each had a two inch gap along the center where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure the corridor doors</p>	K 0029	<p>Director was educated on smoke barrier set door requirements (See Attachment A).4. The inspection of the facility's smoke barrier set doors will continue to be documented on the facility preventative maintenance log and will be reviewed during the quarterly quality assurance meeting to ensure continued compliance.5. The above corrective action will be completed on or before July 15, 2015.</p> <p>K029 Requires the facility to ensure the corridor doors, such as a storage room for</p>	07/15/2015

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K 0048 SS=F Bldg. 01	<p>to 1 of 3 hazardous areas, such as a storage room for combustibles over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects staff who use the central supply room in the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 06/15/15 at 11:40 a.m. with the maintenance supervisor, the Service Hall central supply room, which each measured one hundred sixty eight square feet and stored fifteen shelves of cardboard boxes of paper supplies, plastic containers, adult briefs and plastic nursing supplies, lacked a self closing device on the door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>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 Based on record review and interview, the facility failed to provide 1 of 1 written emergency fire safety plan that</p>	K 0048	<p>combustibles over 50 square feet in size, was provided with a self-closing device which would cause the door to close and latch into the door frame. 1. The Service Hall central supply room had a self-closing device placed on the door. 2. All staff utilizing the Service Hall central supply room have the potential to be affected. All corridor doors were inspected to ensure that self-closing devices were placed on the door if the room size is over 50 feet in size and have combustibles.3. The Maintenance Director was educated on the regulation of the corridor doors needing to have self-closing doors in a room size over 50 feet in size and have combustibles (See Attachment A).4. A review of the corridor doors will continue to be addressed by the maintenance director and will be reviewed during the quarterly quality assurance meeting to ensure continued compliance.5. The above corrective action will be completed on or before July 15, 2015.</p> <p>K048 Requires the facility to provide a written fire safety plan including all items listed in NFPA 101, Section 19.7.2.2. 1. The</p>	07/15/2015			

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K 0050	<p>incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to 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. <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on record review on 06/15/15 at 1:20 p.m. with the administrator, the facility's fire safety plan labeled Disaster Manual dated 2012 did not address the use of the K class fire extinguisher located in the kitchen in relationship to the use of the kitchen overhead extinguishing system. This was verified by the administrator at the time of record review and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b) NFPA 101</p>		<p>facility's fire safety plan was written to address the use of the K class fire extinguisher located in the kitchen in relationship to the use of the kitchen overhead extinguishing system and the incorrect fire plan was inadvertently given to the surveyor. 2. All residents residing in the facility have the potential to be affected. The Regional Director reviewed the fire safety plan to ensure the most updated policies were in place. 3. The Maintenance Director was educated on the fire safety plan and a copy was placed in his disaster manual (See Attachment A)4. The review of the fire safety plan will continue to be addressed and will be reviewed during the quarterly quality assurance meeting to ensure continued compliance.5. The above corrective action will be completed on or before July 15, 2015.</p>				

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SS=F Bldg. 01	<p>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 conduct quarterly fire drills on all shifts for 2 of 4 quarters and 2 of 3 shifts over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill Reports with the maintenance supervisor on 06/15/15 at 9:20 a.m., there was no fire drill report for the first shift and second shift, fourth quarter of the year 2014 and a first shift fire drill for the first quarter for the year 2015. Additionally, based on interview with the maintenance supervisor during the review of the Monthly Fire Drill Reports, there was no other documentation available for review to verify these missed drills were conducted. This was verified by the maintenance supervisor at the time of</p>	K 0050	<p>K050 Requires the facility to conduct quarterly fire drills on all shifts. 1. The facility's fire drill reports were reviewed. A schedule is in place to ensure that fire drills are conducted at least quarterly on each shift. 2. All visitors, staff and residents residing in the facility have the potential to be affected. A schedule is in place to ensure that fire drills are conducted per regulations.3. The Maintenance Director was educated on the fire drill schedule and the importance of conducting the drills per regulation (See Attachment A)4. A review of the fire drills will continue to be addressed by the administrator and will be reviewed during the quarterly quality assurance meeting to ensure continued compliance.5. The above corrective action will be completed on or before July 15, 2015.</p>	07/15/2015

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K 0056 SS=F Bldg. 01	<p>record review and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 main dining room was sprinkled. This deficient practice affects 43 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 06/15/15 at 12:10 p.m. with the maintenance supervisor, the main dining room ceiling had six, eight foot by eight foot enclosed areas with one foot bulkheads not provided with sprinkler coverage. This</p>	K 0056	<p>K056 Requires the facility to ensure the dining room is sprinkled. 1. The Dining Room will have sprinkler coverage installed in the noted area. SafeCare is to provide the facility with a quote for installation of the additional sprinkler heads with the work to be scheduled upon receipt of the quote. 2. All visitors, staff and residents utilizing the Dining Room have the potential to be affected. The Maintenance Director has completed checks throughout the facility to ensure all areas are appropriately sprinklered. 3. The Maintenance Director was</p>	08/25/2015

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K 0062 SS=F Bldg. 01	<p>was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on record review and interview, the facility failed to ensure a complete flushing program was conducted after an obstruction investigation was conducted on 1 of 1 automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 10-2.3 requires if an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all residents, staff and</p>	K 0062	<p>educated on the standard for installation of sprinkler systems (See Attachment A) 4. A review of the the sprinkler system will continue to be addressed by the maintenance director through the quarterly quality assurance meeting to ensure continued compliance. 5. The above corrective action will be completed on or before August 25th, 2015.</p> <p>K062 Requires the facility to ensure a complete flushing program is conducted after an obstruction investigation was conducted on automatic dry sprinkler piping system which indicated the presence of scale and silt buildup in the sprinkler piping. 1. The sprinkler system will be flushed per recommendation. An outside venfor has been contacted to complete a quote for the for the necessary line flushing, with the work to be scheduled upon receipt of the quote. The sprinklers that show corrosion have been cleaned or replaced. 2. All visitors, staff and residents residing in the facility have the potential to be affected. Sprinkler system will be</p>	08/25/2015

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	<p>visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 06/15/15 at 9:40 a.m., the most recent sprinkler system internal pipe inspection from Safecare was dated 02/23/15. Furthermore, the results of the inspection indicated "found 4" cross main above room #207 and 208 and 4" cross main above room #216 and 217 are filled with rust and debris. Also replaced leaking 4" end cap on 4" cross main above room #207. Send quote to flush fire sprinkler system." Based on an interview with the maintenance supervisor on 06/15/15 at 9:55 a.m., when asked if the sprinkler system flushing was conducted as a follow up action to the internal pipe inspection report dated 02/23/15, the maintenance supervisor stated the facility did not have the complete sprinkler flushing conducted. The lack of recommended follow up action taken after the internal pipe inspection of the sprinkler system was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p>		<p>scheduled to be flushed upon receipt of a quote from an outside vendor. All sprinklers were cleaned or replaced in the facility if corrosion was noted. 3. The Maintenance Director was educated on the standard for flushing the sprinkler systems and maintaining the sprinklers from corrosion (See Attachment A) 4. A review of the the sprinkler system will continue to be addressed by the maintenance director through the quarterly quality assurance meeting to ensure continued compliance. 5. The above corrective action will be completed on or before August 25th, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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	<p>2. Based on observation and interview, the facility failed to replace 10 of over 300 sprinklers in the facility covered in corrosion or loaded. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested 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 all residents who use the front entrance during an evacuation or use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observations on 06/15/15 during a tour of the facility from 9:10 a.m. to 1:30 p.m. with the maintenance supervisor, the following locations had sprinklers which were either corroded or loaded;</p> <ol style="list-style-type: none"> 1. The outside front entrance porch overhang had two sprinklers completely covered in green corrosion. 2. The 100 Hall mechanical room sprinkler was completely covered in green corrosion. 3. The outside Service Hall porch 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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K 0130 SS=F Bldg. 01	<p>overhang sprinkler was completely covered in green corrosion.</p> <p>4. The laundry wash room had two sprinklers completely covered in green corrosion.</p> <p>5. The kitchen had five sprinklers completely loaded with brown grease and dust.</p> <p>This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to ensure 3 of 3 hot water heaters/boilers had an inspection certificate that were current to ensure the boilers were in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 29 residents who reside on the 100 Hall near the 100 Hall boiler room.</p> <p>Findings include:</p> <p>Based on review of the 100 Hall boiler</p>	K 0130	<p>K0130 Requires the facility to ensure hot water heaters/boilers have an inspection certificate that is current to ensure the boilers are in safe operating conditions. 1. The hot water heaters/boilers were inspected. 2. All staff and residents residing in the facility have the potential to be affected. Hot water heaters/boilers were inspected and inspection certificates are current and posted appropriately. 3. The Maintenance Director was educated on the standard for needing the hot water heaters/boilers to be inspected to minimize the possibility of a fire emergency requiring evacuation</p>	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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K 0143 SS=A Bldg. 01	<p>room three A O Smith model hot water heater inspection certificates with the maintenance supervisor on 06/15/15 at 11:45 a.m., the inspection certificates for hot water heater #312093, #292663, and #312094 each had an expiration date of 09/25/14. Based on an interview with the maintenance supervisor on 06/15/15 at 11:55 a.m., it was stated there is no current two year inspection certificate for the three hot water heaters in the 100 Hall boiler room. The lack of current inspection certificate for three A O Smith model hot water heaters was verified by the maintenance supervisor at the time of interview and record review and acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating</p>		of occupants (See Attachment A)4. A review of the hot water heaters/ boilers will continue to be addressed by the maintenance director through the quarterly quality assurance meeting to ensure continued compliance.5. The above corrective action will be completed on or before July 15, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2015	
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203			
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	<p>that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage/transfer locations was provided with a sign indicating the transferring of oxygen occurs. This deficient practice could affect staff who transfer oxygen at the outside Service Hall liquid oxygen storage location.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 06/15/15 at 12:30 p.m., the outside Service Hall liquid oxygen storage location, where six full liquid oxygen containers were stored, lacked a sign indicating the transferring of oxygen occurred at the location.</p> <p>Based on an interview with the administrator on 06/15/15 at 12:50 p.m., it was stated the Service Hall outside liquid oxygen storage location is used to transfer liquid oxygen into smaller portable containers. The lack of a sign indicating the transfer of oxygen is occurring at the outside Service Hall liquid oxygen storage location was acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p>	K 0143	<p>K0143 Requires the facility to ensure that the transfer of oxygen occurs in an area posted with signs that indicate transfer is occurring.1. A sign has been installed at the outside Service Hall liquid oxygen storage location to indicate that oxygen transfer occurs at that location.2. All staff who transfer oxygen have the potential to be affected; thus the following corrective action was taken3. The Maintenance Director was educated on ensuring that all liquid oxygen transfer and storage locations are equipped with appropriate signage to indicate that oxygen is transferred at that location (See Attachment A) 4. The facility administrator or designee will monitor monthly to ensure that appropriate signage remains in place. This will be reviewed during the quarterly quality assurance meeting to ensure continued compliance.5. The above corrective action will be completed on or before July 15, 2015.</p>	07/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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K 0144 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator with over 100 horsepower was equipped with a remote manual stop. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on an interview with the maintenance supervisor on 06/15/15 at 9:15 a.m., the facility had one emergency generator set powering the facility during periods of power outages. Based on observation of the emergency</p>	K 0144	<p>K0144 Requires the facility to ensure the emergency generator is equipped with a remote manual stop and also requires the facility to have monthly load tests. 1. The generator has been tested under load and verified to be operating at at least 30 percent of the EPS name plate rating. The emergency generator will be equipped with a remote manual stop. An outside vendor has been contacted to provide a quote for the addition of the remote manual stop. The work will be scheduled upon receipt of the quote. 2. All residents residing in the facility have the potential to be affected. The load test was appropriately documented in the facility preventative maintenance log. The emergency generator will be equipped with a remote manual stop. 3. The Maintenance Director was educated on the appropriate documentation of the generator load test and the importance of the emergency generator being equipped with a remote manual stop (See Attachment A) 4. The generator load test will continue</p>	08/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203		
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	<p>generator set outside the Service Hall transformer room on 06/15/15 at 9:25 a.m. with the maintenance supervisor, the emergency generator set nameplate indicated the machine was a four hundred fifty four cubic inch motor. Based on an interview at the time of observation, the maintenance supervisor indicated the generator set is a three hundred horse power machine and when asked if the emergency generator was provided with a remote manual stop switch, the maintenance supervisor indicated there is no remote manual stop switch. The lack of a remote manual stop switch for the emergency generator was acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document monthly load tests for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a</p>		<p>to be documented on the facility preventative maintenance log and also ensuring that the emergency generator is equipped with a remote manual stop. This will be reviewed during the quarterly quality assurance meeting to ensure continued compliance. 5. The above corrective action will be completed on or before August 25th, 2015.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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	<p>minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Weekly Log for the emergency generator with the maintenance supervisor on 06/15/15 at 9:30 a.m., the load tests were documented over the past year on a weekly basis by recording the amperage output which was listed under each weekly test. Based on an interview with the maintenance supervisor on 06/15/15 at 9:40 a.m., when asked if the amperage output listed for each weekly load test was converted to a percent of load, the maintenance supervisor indicated he did not know how to convert amperage to a percent of load. The lack of a documented load tests showing either a calculated method of the listed thirty percent of the emergency power system's</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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K 0154 SS=C Bldg. 01	<p>name plate rating or the load being maintained at exhaust gas temperatures was acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 59 of 59 residents in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, standard for Inspection, Testing and maintenance of water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include</p>	K 0154	<p>K0154 requires the facility to notify the authority having jurisdiction in the event the automatic sprinkler system is out of service for more than 4 hours in a 24-hour period.1. The facility disaster manual was reviewed and updated to include a sprinkler system impairment policy and procedure which includes directive to contact the insurance company, local fire department and the Indiana State Department of Health, whose contact information is found within the disaster manual, in the event the automatic sprinkler system is out of service for more than 4 hours in a 24-hour period. 2. All</p>	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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K 0155 SS=C Bldg. 01	<p>evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 06/15/15 at 1:30 p.m. with the administrator, the facility's written policy in the event the automatic sprinkler system was placed out of service lacked phone numbers for notification of the Indiana State Department of Health, the local fire department, and the insurance carrier. This was acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is</p>		<p>residents have the potential to be affected; thus the facility disaster plan was reviewed and updated to include applicable contact information.3. The Administrator was educated on ensuring contact information is available and accurate for applicable entities within the facility disaster manual (See Attachment A).4. The facility disaster plan will be updated as needed and will be reviewed quarterly as part of the quarterly quality assurance meeting. The plan of action will be adjusted, as warranted.5. The above corrective action will be completed on or before July 15, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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	<p>notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a written policy for the protection for 59 of 59 residents in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period for the Henry County Memorial Hospital building in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents in the facility.</p> <p>Findings include: Based on record review on 06/15/15 at 1:30 p.m. with the administrator, the</p>	K 0155	<p>K0155 requires the facility to notify the authority having jurisdiction in the event the fire alarm system is out of service for more than 4 hours in a 24-hour period.1. The facility disaster manual was reviewed and updated to include a fire watch (impairment coordinator) policy and procedure which includes directive to contact the insurance company, local fire department and the Indiana State Department of Health, whose contact information is found within the disaster manual, in the event the fire alarm system is out of service for more than 4 hours in a 24-hour period. 2. All residents have the potential to be affected; thus the facility disaster plan was reviewed and updated to include applicable contact information.3. The Administrator was educated on ensuring contact information is available and accurate for applicable entities within the facility disaster manual (See Attachment A)4. The facility disaster manual will be updated as needed and will be reviewed quarterly as part of the quarterly quality assurance meeting. The plan of action will be adjusted, as warranted.5. The above corrective action will be completed on or before July 15,</p>	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/15/2015
NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203		
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	<p>facility's written policy in the event the fire alarm system was placed out of service lacked phone numbers for notification of the Indiana State Department of Health, the local fire department, and the insurance carrier. This was acknowledged by the administrator at the exit conference on 06/15/15 at 1:30 p.m.</p> <p>3.1-19(b)</p>		2015.		