

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 08/18/2014
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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: 08/18/14</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 and in areas open to the corridor. Resident rooms are</p>	K010000		
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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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K010018 SS=E	<p>equipped with battery powered smoke detectors. The facility has a capacity for 52 and had a census of 49 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 08/19/14.</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 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</p>				

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	<p>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 2 of 6 smoke compartments were not prevented from closing. This deficient practice affects visitors, staff, and 10 or more residents on the C hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/18/14 at 4:00 p.m., openings to the corridor from resident rooms were protected by a set of double doors for which one leaf for the inactive door in each door set had an automatic latch which latched into the top of the door frame when closed and could be opened by pulling on a chain. Both leaves in the door sets for resident rooms 121 and 123 were open. When the inactive doors for these rooms were pushed to close, they did not. Latches for both inactive doors hit the top of the door. The maintenance director said at the time of observation, these overhead door latches needed an adjustment.</p>	K010018	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The inactive door leafs for room 121 & 123 were adjusted so the doors close and latch properly when they are pushed closed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The maintenance director and HFA shall examine all doors in the building to ensure all doors close and latch properly. 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 rounds to ensure all doors close and latch properly. How the corrective actions will be monitored to ensure the deficient practice will not recur: The maintenance director shall report to the QA committee. The QA committee shall review and provide suggestions if necessary. Date Completed: 8-18-14</p>	08/18/2014

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 smoke barrier door sets were held open only by devices which would allow them to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 20 or more residents in the E, B and C smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director and administrator on 08/18/14 at 3:40 p.m., one door in the double smoke barrier door set between the E and B wing smoke compartments did not close when tested manually with the maintenance director. One door in the door set hit the door coordinator which failed to allow the door to close.</p>	K010021	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Double smoke barrier door set between the E and B wing smoke compartments were repaired allowing the doors to properly close automatically and manually. The smoke barrier door set between the B and C wing was repaired with a door coordinator which ensured the door with the astragal to close first. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The maintenance director and HFA shall examine all double smoke barrier doors in the building to ensure all doors close properly and check to ensure coordinator is working properly. What</p>	08/20/2014			

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	<p>The maintenance director made an adjustment at the time of observation and the doors closed, however, the door failed to automatically close when the fire alarm was activated at 3:45 p.m. on 08/18/14. The maintenance director acknowledged at the time of observation, the coordinator was not allowing the doors to close.</p> <p>b. Based on observation with the maintenance director and administrator on 08/18/14 at 3:00 p.m., one door in the smoke barrier door set between the B and C wing smoke compartments was equipped with an astragal. When the doors were closed allowing the door with the astragal to close first, the astragal prevented the second door from closing into the door frame. The maintenance director said at the time of observation, he took the door coordinator off the door frame "yesterday" for adjustment and hadn't had time to reinstall it.</p> <p>3.1-19(b)</p>		<p>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 rounds to ensure smoke barrier doors automatically close and that the double door coordinators work properly. How the corrective actions will be monitored to ensure the deficient practice will not recur: The maintenance director shall report results to the QA committee. The QA committee shall review and provide suggestions if necessary. Date completed 8-20-14</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 smoke barrier penetrations in 1 of 6 sprinklered smoke compartments were sealed in a manner which maintained the one half hour fire resistance rating. This deficient practice could affect visitors, staff and 8 or more residents in the A wing smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/18/14 at 3:05 p.m., an attic access panel was located in the ceiling of the A wing storage closet. The panel was damaged and fit poorly allowing gaps of one and two inches into the attic space above.</p>	K010025	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Attic access panel in the ceiling of the wing A storage closet was replaced and repaired to ensure a proper fit without any gaps. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The maintenance director and HFA shall examine all access panels in the building to ensure there is not any damage and/or gaps. 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 rounds to ensure all access panels have a secure fit and there are not any damage</p>	08/22/2014			

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K010038 SS=E	<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>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure doors in 1 of 5 emergency exits were readily accessible. This deficient practice affects visitors, staff and 10 or more residents on the C wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/18/14 at 3:10 p.m., the emergency exit doors for C wing were equipped with panic bars which when pushed, should allow the doors to open. The doors could not be immediately opened because a long strip of Velcro had been wrapped around the panic bars on both doors and tied. The door could not be opened without untying it. The maintenance</p>	K010038	<p>and/or gaps. How the corrective actions will be monitored to ensure the deficient practice will not recur: The maintenance director shall report results to the QA committee. The QA committee shall review and provide suggestions if necessary. Date completed: 8-22-14</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Velcro on the emergency exit door for C wing was immediately removed allowing the exit to be readily accessible. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The maintenance director and HFA shall examine all emergency exits in the building to ensure the exits are readily accessible. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Re-educate staff on the facility emergency policies and procedure. The maintenance director and HFA shall examine</p>	09/03/2014			

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K010048 SS=F	<p>director said at the time of observation, he was "not sure why the doors are tied like that."</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 develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 39 of 39 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the 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 This deficient practice could affect all occupants.</p>	K010048	<p>emergency exits daily to ensure exits are readily accessible at all times. How the corrective actions will be monitored to ensure the deficient practice will not recur: The maintenance director and HFA shall report results to the QA committee. The QA committee shall review and provide suggestions if necessary. Date completed: 9-3-14</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Policy/Procedure for the response to battery powered smoke detectors was located, reviewed, and revised. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The HFA and maintenance director shall review all policy manuals to ensure policy is accessible. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Reeducate staff on policy/procedure for the response to battery powered smoke detectors. The HFA and maintenance director shall routinely check and update</p>	08/29/2014			

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	Findings include: Based on review of the Fire Policy and Procedures with the maintenance director and administrator on 08/18/14 at 4:30 p.m., the plan did not address the location of, and special response required, for battery powered smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The administrator confirmed at the time of record review, he could find no procedure for response to the local alarms of battery powered smoke detectors. 3.1-19(b)		policies as needed. How the corrective actions will be monitored to ensure the deficient practice will not recur: The QA committee shall review all policies to ensure completion. The QA committee shall review and provide suggestions if necessary. Date completed: 8-29-14				
K010062 SS=E	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 facility failed to ensure sprinkler heads providing protection for 1 of 5 smoke	K010062	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Escutcheon	08/29/2014			

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	<p>compartments were maintained. This deficient practice could affect staff, visitors and 20 or more residents in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/18/14 between 2:30 p.m. and 5:00 p.m., the sprinkler head escutcheon in the clean laundry was missing and one escutcheon for a kitchen sprinkler head was improperly installed or displaced leaving an annular gap of one half inch into the attic above. The maintenance director acknowledged the aforementioned conditions at the time of observations.</p> <p>3.1-19(b)</p>		<p>in the clean laundry was replaced and the escutcheon in the kitchen was repaired to close the gap. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The maintenance director and HFA shall review all sprinkler head escutcheons in the building to ensure they are appropriately installed. 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 examine sprinkler head escutcheons monthly to ensure they are properly installed. How the corrective actions will be monitored to ensure the deficient practice will not recur: The maintenance director shall report results to the QA committee. The QA committee shall review and provide suggestions if necessary. Date completed: 8-29-14</p>				