

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
--	---

(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
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: 05/12/14</p> <p>Facility Number: 011596 Provider Number: 155769 AIM Number: 200901690</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Morrison Woods Health Campus was found not in compliance with Requirements for Participation in Medicare, 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 18, New 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has</p>	K010000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during the recertification and state licensure survey on May 12, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider is respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
--	---

(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
K010046 SS=F	<p>a capacity of 68 and had a census of 54 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility had no detached buildings.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/15/14.</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 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review and interview, the facility failed to provide complete documentation of functional tests for 1 of 1 battery operated lights at the generator. NFPA 110, 5-3-1 requires lighting at the emergency generator. LSC Section 7.9.3 requires a functional test be conducted on every required emergency lighting system at 30 day intervals for not less than 30</p>	K010046	<p><b>Corrective Actions accomplished for those residents found to be affected by the alleged deficient practice:</b> This alleged deficient practice could affect all occupants in the facility including staff, visitors, and residents.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged</b></p>	06/02/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/12/2014	
NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304			
(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			
K010052 SS=F	<p>seconds and an annual test for not less than 1 1/2 hours. This deficient practice could affect all occupants in the facility including staff, visitors and residents if the generator was impaired and there was no functional emergency battery powered light available.</p> <p>Findings include:</p> <p>Based on Fire Safety Record review on 05/12/14 at 3:13 p.m. with the Maintenance Director, the facility tested the battery back up emergency light by the generator monthly, but did not document any length of time. In addition, a 90 minute annual test was not available for review. Based on interview on 05/12/14 at 3:15 p.m. with the Maintenance Director, it was acknowledged the battery back up emergency light at the generator was checked monthly, but no documentation for the duration of the monthly or annual test was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical</p>		<p><b>deficient practice and corrective actions taken:</b> This alleged deficient practice could affect all occupants in the facility including staff, visitors, and residents. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:</b> Maintenance Director will use a log to document all monthly 30 second tests and the 90 minute annual test. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The Maintenance Director will provide log to Executive Director monthly and make report to Q.A. Committee on a monthly basis for the next 6 months then randomly thereafter.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/12/2014	
NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304			
(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			
	<p>Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems once a component of the system had failed such as a secondary power supply. NFPA 72, National Fire Alarm Code, Chapter 7-1.1.2 requires system defects and malfunctions shall be corrected. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the Fire alarm annual "Inspection and Testing Form" on 05/12/14 at 3:00 p.m. with the Maintenance Director, it was stated in the comments section of the report, which was done on 04/08/14, "the batteries failed test." Based on interview on 05/12/14 concurrent with the record review, it was acknowledged by the Maintenance Director the facility was informed of the failure of the battery test, and after consulting with the testing vendor it was confirmed the batteries had failed a load test during the inspection on 04/08/14 and they have not been replaced.</p> <p>3.1-19(b)</p>	K010052	<p><b>Corrective Actions accomplished for those residents found to be affected by the alleged deficient practice:</b> This alleged deficient practice could affect all occupants in the facility including staff, visitors, and residents.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> This alleged deficient practice could affect all occupants in the facility including staff, visitors, and residents. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:</b> Fire Protection Company identified on 4/8/14 that batteries failed the test. Fire Protection Company returned on 4/15/14 to replace the batteries and determined that they would need to order the proper batteries. At the time of the Life Safety Inspection, the Facility was still waiting on the Fire Protection Company to replace the batteries. Moving forward, when the batteries are identified as failing the test, new batteries will be procured within 48 hours by either the Fire Protection Company or Facility. <b>How the corrective</b></p>	06/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/12/2014	
NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304			
(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			
K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p>	K010062	<p><b>measures will be monitored to ensure the alleged deficient practice does not recur:</b> The Maintenance Director will provide the Executive Director with all reports from the Fire Protection Company within 24 hours of each visit. The Maintenance Director will report to Q.A. Committee on any testing conducted by the Fire Protection Company on a monthly basis for the next 6 months and randomly thereafter.</p> <p><b>Corrective Actions accomplished for those residents found to be affected by the alleged deficient practice:</b> This alleged deficient practice could affect all occupants in the facility including staff, visitors, and residents. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> This alleged deficient practice could affect all occupants in the facility including staff, visitors, and residents. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not occur:</b> Facility will retain Fire</p>	06/02/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/12/2014	
NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304			
(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			
	<p>Based on review of Fire Systems report on 05/12/14 at 3:31 p.m. with the Maintenance Director, the facility lacked documentation of annual inspections for two private fire hydrants outside the south and west portion of the facility. Based on interview concurrent with record review with the Maintenance Director, it was confirmed documentation of an annual fire hydrant inspection was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1-11.1 requires maintenance shall be performed to keep the sprinkler system equipment operable or to make repairs. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of sprinkler inspection reports on 05/12/14 at 3:17 p.m. with the Maintenance Director, it was reported in</p>		<p>ProtectionCompany or local municipality to conduct annual inspection of 2 private fire hydrant and provide needed documentation. The required repairs will be made to ensure that the "tamper switch" on the post indicator valve is fully functioning. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The Maintenance Director will provide the Executive Director with all reports from the Fire Protection Company within 24 hours of each visit. The Maintenance Director will report to Q.A. Committee on any testing conducted by the Fire Protection Company on a monthly basis for the next 6 months and randomly thereafter.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/12/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
--	---

(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
	<p>the comments section "the tamper switch on the Post Indicator Valve (PIV) did not work." Based on interview on 05/12/14 at 3:17 p.m. with the Maintenance Director, it was acknowledged the facility knew about the failure of the tamper switch on the PIV, but repairs have not been done.</p> <p>3.1-19(b)</p>			