STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 05/20/2014
NAME OF PROVIDER OR SUPPLIER WILLOW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010000	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: 05/20/14 Facility Number: 000016 Provider Number: 155042 AIM Number: 100291500 Surveyor: Lex Brashear, Life Safety Code Specialist 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, in spaces open to the corridors, and in all resident sleeping rooms. The	K010000	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 requests that the plan of correction be considered our allegation of compliance effective June 19, 2014 to the Life Safety Code Recertification Survey conducted on May 20, 2014.	

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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	facility has a capacity of 170 and had a census of 140 at the time of this survey. All areas where the residents have customary access were sprinklered. 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 by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/27/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.			

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	(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where cigarettes were smoked. This deficient practice could affect up to 5 residents at a time while in the resident smoking building, plus staff and visitors while also in the resident smoking building and on the grounds outside the smoking building. Findings include: Based on observation on 05/20/14 at 11:45 a.m. during a tour of the facility with the Maintenance Director, there were two metal cigarette butt containers within the residential smoking building. Both metal containers contained a mixture of cigarette butts and paper trash. Furthermore, the area outside the smoking building was littered with hundreds of cigarette butts including the sidewalks, grass areas, and parking lot. This was acknowledged by the Maintenance Director at the time of observation.	K010066	**K066 It is the practice of Willow Manor to assure that resident smoking areas are kept clean and cigarette butts are properly disposed of.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** There are no specific residents identified. The resident smoking area has been cleaned with cigarette butts disposed of properly. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff has been in-serviced related to fire safety and the appropriate disposition of cigarette butts in the resident smoking area. This area will be monitored routinely to assure that the area stays free of potential fire hazard. Please see below for means of monitoring. ***The corrective action taken to***	06/19/2014

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	3.1-19(b)		***monitor performance to assure compliance through quality assurance is:*** A performance Improvement Tool has been implemented that will review this area randomly 5 times weekly. The review will include assuring that cigarette butts are disposed of properly. Any identified issues will be immediately corrected. The Administrator, or designee, will be responsible for completion of the PI tool. The completed tools will be reviewed at the regularly scheduled QA meetings with additional recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** June 19, 2014	
K010144 SS=C	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. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for 2 of 2 emergency generators was available for 35 of 52 weeks. NFPA 99, 3-4.4.1.3 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall	K010144	**K144** **It is the practice of Willow Manor to assure that the emergency generators are checked in accordance with the regulatory guidelines.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** There are no specific residents identified. Please see under systems implemented to assure compliance with this tag. ***Other residents that have the***	06/19/2014

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	be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires storage batteries, including electrolyte levels, be inspected at intervals of not more than 7 days. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly. NFPA 99, 3-4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on review of the facility's Emergency Generator Log on 05/20/14 at 10:30 a.m. with the Maintenance Director present, there was no weekly generator documentation available to show visual inspections of the two generators hoses, belts, oil level, etc., plus the generator's starting batteries since September 12, 2013. Based on interview at the time of record review, the Maintenance Director confirmed there was no weekly documentation available to show weekly inspections of the two generators starting batteries since September 12, 2013. Furthermore, the Maintenance Director		***potential to be affected have been identified by:*** Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The Maintenance Staff has been in-serviced on assuring that the emergency generators/starting batteries are properly checked on a weekly basis including hoses, belts, oil levels, etc in accordance with the regulatory guidelines. The Maintenance Director is responsible for assuring that the documentation properly reflects the weekly observations/reviews. Please see below for means of monitoring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Maintenance Director is responsible for assuring that the weekly checks for the emergency generators occurs in accordance with the regulations and that the review is documented on the preventive maintenance log. In addition, a Performance Improvement Tool has been established to review the preventive Maintenance log to assure that it reflects the appropriate documentation. This tool will be completed weekly x3, monthly x3,	

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	said the two generators start automatically on a weekly basis. 3.1-19(b)		and quarterly x3. The Administrator, or designee, will be responsible for completion of the tool which reviews the preventive maintenance documentation. Any identified issues will be immediately corrected. The PI tool will be reviewed at the regularly scheduled QA meetings with additional recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** June 19, 2014	