

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 10/31/2011
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN47203
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K0000	<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: 10/31/11</p> <p>Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</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, 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility</p>	K0000		

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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K0014 SS=F	<p>has a capacity of 80 and had a census of 63 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/03/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation, record review and interview; the facility failed to ensure interior finishes for 3 of 3 exit corridor walls had a flame spread rating of Class A or Class B. This deficient practice could affect all 63 residents in the facility as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 10/31/11 during a tour of the facility between 12:00 p.m. to 4:00 p.m. with the Maintenance Supervisor, the corridors in 100, 200 and the administrative halls had an interior finish of carpet on the bottom two feet of</p>	K0014	<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.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p>	11/14/2011	

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	<p>the corridor walls. Based on review of Flame Spread records on 10/31/11 at 3:29 p.m., there was no documentation to verify the flame spread ratings of the aforementioned corridor walls with carpet. Based on interview on 10/31/11 at 3:31 p.m. with the Maintenance Supervisor, it was acknowledged the facility does not have any documentation to confirm the carpet installed on all corridor walls had a flame spread rating of class A or B.</p> <p>3.1-19(b)</p>		<p><b>K014</b> <b>Interior finish for corridors has a flame spread rating of Class A or B.</b></p> <ol style="list-style-type: none"> <li>No residents or visitors were harmed by this practice.</li> <li>All residents and visitors have the potential to be affected.</li> <li>Facility will purchase from Crossman Fire &amp; Safety, Inc. FRP5 Fire Retardant. Awaiting the delivery of this product to apply to the carpet on the corridor walls. (See attachment 1 copy of check request)</li> <li>Completing application of product on the corridor walls application will be processes for the certificate of fire-resistance from NY Fire-Shield Inc.</li> <li>To ensure continued compliance of maintaining appropriate fire retardant rating information, this fire rating documentation will remain in the facility as proof of flame spread rating with the maintenance director.</li> <li>The above corrective measures will be completed on or before 11/14/11.</li> </ol>		

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K0018 SS=E	<p>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 1 of 8 corridor doors on the Service corridor would latch into its frame. This deficient practice could affect 10 residents in the adjacent dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/31/11 at 1:20 p.m. with the Maintenance Supervisor, the door leading into the Janitor's room on Service hall was missing the doorknob lockset and consequently would not latch into its frame. Based on interview on 10/31/11 at 1:25 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door would not latch into its frame.</p> <p>3.1-19(b)</p>	K0018	<p><b>K018</b> Doors protecting corridor openings ...are provided with a means suitable for keeping the door closed.</p> <p>1.No residents or staff was harmed by this practice.</p> <p>1.All staff has the potential to be affected by this practice.</p> <p>1.The doorknob lockset was immediately (10/31/11) replaced with a new lockset in the service hallway.</p> <p>1.Staff was inserviced on the use of Repair Order forms to report items in the facility that are in need of maintenance attention. (see attachment 2) To ensure ongoing compliance Repair Order forms will remain available at the nurses' station, and in front of the maintenance and housekeeping doors. The maintenance director during his quality assurance rounds will</p>	11/14/2011	

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K0029 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 doors leading to hazardous areas such as rooms with combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 32 residents on 100 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/31/11 at 1:59 p.m. with the Maintenance Supervisor, the Activities room on 100 hall was greater than fifty square feet in size and stored twenty five combustible cardboard boxes without a self closing device on the corridor door.</p> <p>Based on interview on 10/31/11 at 2:02 p.m. with the Maintenance Supervisor, the</p>	K0029	<p>monitor door closing devices. 1.This above corrective measure was completed on November 14, 2011.</p> <p><b>K029</b> "...hazardous areas with combustible items must be provided with self closing devices..."</p> <p>1. No residents, visitors or staff was harmed by this practice. 2.All staff, visitors and residents have the potential to be affected by this practice.</p> <p>1.A self closing door device was placed on the door for the Activities storage room. (November 1, 2011).</p> <p>1.To ensure ongoing compliance the Maintenance Director will include monitoring of door closing devices during his quality assurance rounds.</p> <p>1.The above corrective measure was completed on November 1, 2011.</p>	11/14/2011	

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K0048 SS=E	<p>door leading into the Activities storage room was not equipped with a self closing device on the corridor door.</p> <p>3.1-19(b)</p> <p>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 include the use of 1 of 2 kitchen fire extinguishers in the written Fire Safety plan for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that 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 affects any resident, staff and visitors in the vicinity</p>	K0048	<p><b>K048</b> Written plan for the protection of all patients....</p> <p>1. No residents, staff or visitors were harmed by this practice.</p> <p>2. All staff has the potential to be affected by this practice.</p> <p>3. The written health care occupancy fire safety plan was revised immediately (10/31/2011) to include the mention of the K class fire extinguisher and it's use. ( See attachment 3 )</p> <p>Staff was inserviced on its use and placement in the facility. (See attachment 2)</p> <p>4. To ensure ongoing compliance the new policy has been placed in the new employee hire packets and will be inserviced to all staff annually.</p>	11/14/2011	

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K0062 SS=E	<p>of the kitchen.</p> <p>Findings include:</p> <p>Based on a record review of the facility's written Fire Disaster plan on 10/31/11 at 3:45 p.m. with the Maintenance Supervisor the Fire Disaster plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview on 10/31/11 at 3:50 p.m. with the Maintenance Supervisor, it was acknowledged the written Fire Safety plan for the facility did not include mention of the K class fire extinguisher.</p> <p>3.1-19(b)</p> <p>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>Based on observation and interview, the facility failed to ensure 3 of over 200 sprinkler heads in the facility were maintained. This deficient practice could affect 32 residents on 100 hall and 31 residents on 200 hall as well as staff and visitors.</p>	K0062	<p>5. The above corrective action was completed on 11/14/11</p> <p><b>K062</b> "...automatic sprinkler systems are continuously maintained..." 1. No residents, staff or visitors were harmed. 2. All residents, staff and visitors have to potential to be affected. 3. The two missing escutcheons in the Social Service Director's Office and Medical Records were immediately</p>	11/14/2011

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	<p>Findings include:</p> <p>Based on observations on 10/31/11 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following sprinkler head had either escutcheons missing or had paint on the fusible link:</p> <ul style="list-style-type: none"> <li>a. One sprinkler head escutcheon, Social Service director's office on 200 hall</li> <li>b. One sprinkler head escutcheon, Medical Records office on 100 hall</li> <li>c. One sprinkler head in the Mechanical room on 100 hall had paint on the glass tube.</li> </ul> <p>Based on interview on 10/31/11 concurrent with each observation, it was acknowledged by the Maintenance Supervisor the aforementioned sprinkler heads were either missing escutcheons or had paint on the glass tube.</p> <p>3.1-19(b)</p>		<p>replaced on 10/31/2011. The sprinkler in the Mechanical room was repaired 11/1/2011. 4. To ensure ongoing compliance the Maintenance Director will include monitoring of sprinkling devices during his quality assurance rounds. 5. The above corrective action was completed on 11/1/2011</p>				
K0070 SS=E	<p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide documentation for the use of 2 of 2 portable heating units</p>	K0070	<p><b>K070</b> Portable space heating devices are prohibited...</p> <p>1. No residents, staff or</p>	11/14/2011			

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K0130 SS=E	<p>used in nonsleeping staff areas. This deficient practice could affect 10 residents observed in the Main dining room adjacent to the Administrative hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/31/11 at 2:15 p.m. with the Maintenance Supervisor, the Activities office and the respiratory office on the Administrative hall, adjacent to the Main dining room each contained one portable space heater which was not operating at the time, but documentation was not available to verify the heating elements did not exceed two hundred and twelve degrees F. Based on interview on 10/31/11 at 2:25 p.m. with the Maintenance Supervisor, it was acknowledged the information for the portable heating units, though not in use, was not available for review to verify the portable heating units did not exceed two hundred and twelve degrees F, and a portable heating unit policy was not available for review.</p> <p>3.1-19(b)</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the</p>	K0130	<p>visitors were harmed.</p> <p>2. All residents, staff and visitors have to potential to be affected.</p> <p>3. The two space heaters were immediately removed from the facility. (10-31-2011)</p> <p>4. All staff and contracted service personnel were notified immediately that the use of space heaters is prohibited. All staff were inservice (See attachment 2)</p> <p>5. To ensure ongoing compliance the Maintenance Director will include monitoring of sprinkling devices during his quality assurance rounds.</p> <p>6. The above corrective action was completed on 11/14/2011.</p>	11/14/2011	

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	<p>facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 10 residents observed in the main dining room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 10/31/11 at 12:45 p.m. with the Maintenance Supervisor, there was one metal rolling fire door protecting the opening from the kitchen to the main dining room without an attached inspection tag. The main dining room was not open to the corridor and did not close with actuation of the fire alarm system. Based on interview on 10/31/11 at 12:50 p.m. with the Maintenance Supervisor there was no additional documentation of an annual inspection or test to check for proper operation and full closure.</p>		<p><b>K130 Miscellaneous</b></p> <ol style="list-style-type: none"> <li>No residents, staff or visitors were harmed.</li> <li>All residents, staff and visitors have to potential to be affected.</li> <li>Facility Fire Protection Company has been in the facility to assess order the parts have necessary to appropriately connect the rolling fire door in the kitchen to the fire panel.</li> <li>It will be inspected and tested to document compliance of proper operation and full closure.</li> <li>To ensure ongoing compliance the Maintenance Director will include monitoring of the annual testing of the rolling fire door in concert with the annual fire inspection.</li> <li>The above corrective action was completed on 11/14/2011.</li> </ol>		

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