

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2013
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NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
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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: 10/03/13 & 10/04/13</p> <p>Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Woodland Hills Care 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 three story facility with a basement was determined to be of Type II (222) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, in the corridors, in spaces open to the corridors and hard wired</p>	K010000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under the 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 findings, please find the sufficient documentation providing the evidence of compliance with the plan of correction. The documentation servers to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper 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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	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 90 and had a census of 49 at the time of this survey.</p> <p>All areas providing facility services were sprinkled and all areas where residents have customary access were sprinkled.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/09/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<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 18 of 111 corridor doors were constructed to resist the passage of smoke. This deficient practice could affect 10 residents on the first floor, 10 residents on the second floor, 12 residents on the third floor and 1 resident who uses the basement beauty shop at a time.</p> <p>Findings include:</p> <p>Based on observations on 10/04/13 during a tour of the facility from 11:00 a.m. to 3:30 p.m. with the administrator and maintenance supervisor, the following corridor metal doors failed to resist the passage of smoke because the outside and inside door panels were separating from</p>	K010018	<p>1. The basement beauty shop and 17 resident doors were measured by a Lowe's contractor on 11/6/13 for replacement.</p> <p>2. One beauty salon and 17 resident rooms of the facility have the potential to be affected. Rounds were conducted to ensure no further issues were needing addressed. 3. The maintenance staff was in-serviced on the requirements of fire doors and fire safety 4. The administrator and or designee will conduct quarterly rounds ensuring the resident room doors meet the fire safety specifications. The audits will be reviewed at the quarterly quality assurance meetings. 5. The above corrective measures will be completed on or before January 2, 2014.</p>	01/02/2014			

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	<p>the center section of each door; the basement beauty shop and resident rooms 303, 308, 309, 310, 312, 314, 212, 210, 215, 201B, 204, 105, 102, 106, 101, 109, and 110. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by administrator at the exit conference on 10/04/13 at 3:30 p.m.</p> <p>3.1-19(b)</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>1. Based on observations and interview, the facility failed to ensure 1 of 28 basement room smoke barrier walls 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 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 could affect 12 residents who use the basement therapy room at a time.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance supervisor on 10/04/13 at 11:30 a.m., the basement conference room air handler room west</p>	K010025	<p>1. All identified areas needing appropriate smoke barriers were corrected. Each area now provides the appropriate one half hour fire resistance rating. 2. 12 residents of the facility have the potential to be affected. Rounds were conducted to ensure no further issues were needing addressed. 3. The maintenance staff was in-serviced on the requirements of smoke barriers and fire resistance ratings. 4. The administrator and or designee will conduct quarterly rounds ensuring smoke barrier walls provide at least one half hour fire resistance ratings. The audits will be reviewed at the quarterly quality assurance meetings. 5. The above corrective measures will be completed on or before November 3, 2013.</p>	11/03/2013			

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	<p>wall had a ten inch by twelve inch open area in the concrete block wall and a ten inch area around a water pipe penetration with no fire stopping material used. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged at the exit conference on 10/04/13 at 3:30 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 attic smoke barriers was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 12 residents who may use the basement therapy room at a time.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance supervisor on 10/04/13 at 12:10 p.m., the basement smoke barrier wall above the conference room smoke barrier door had a ten inch area around a water pipe penetration with no fire stopping around the water pipe penetration. This was verified by the administrator and maintenance supervisor at the time of observation, and acknowledged by the administrator at the exit conference on 10/04/13 at 3:30 p.m.</p>						

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 3 of 3 hot water heaters and 1 of 1 boilers had an inspection certificate that was current to ensure they 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 all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the three A O Smith model hot water heaters and Peerless model boiler inspection certificates with the administrator and maintenance supervisor on 10/03/13 at 3:50 p.m., the inspection certificates had an expiration date of 08/05/13. Based on an interview with the administrator and maintenance supervisor on 10/04/13 at 11:00 a.m., it was stated there are no current two year inspection certificates for the three A O Smith model hot water heaters and Peerless model boiler. The lack of current inspection certificates for the three hot water heaters and boiler was acknowledged by the administrator at the</p>	K010130	<p>1. The 3 boilers identified without having an inspection were inspected by the Boiler Division on 10/18/2013.2. All rooms and departments of the facility have the potential to be affected. Rounds were conducted to ensure no further issues were needing addressed.3. The maintenance staff was in-serviced on the requirements of boiler inspections and the process which is needed to keep the certificates current.4. The administrator and or designee will conduct quarterly rounds ensuring the boiler certificates are current. The audits will be reviewed at the quarterly quality assurance meetings.5. The above corrective measures will be completed on or before October 28, 2013.</p>	10/28/2013			

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	exit conference on 10/04/13 at 3:30 p.m. 3.1-19(b)			

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K010143 SS=E	<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 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 1 liquid oxygen storage room/transfer rooms was provided with a 45 minute fire rated door. This deficient practice could affect 12 residents who use the basement therapy room at a time.</p> <p>Findings include:</p> <p>Based on observation on 10/03/13 at 2:35 p.m. with the administrator and maintenance supervisor, the liquid oxygen storage room located next to the basement exit door had a door with no fire rating label. The administrator indicated nursing staff transfill small portable oxygen containers in the liquid oxygen room for resident use. Furthermore, there</p>	K010143	<p>1. The basement liquid oxygen storage room/transfer room door was measured by a Lowe's contractor on 11/6/13 for replacement. 2. The oxygen storage door has the potential to be affected all residents who use the basement. Rounds were conducted to ensure no further issues were needing addressed. 3. The maintenance staff was in-serviced on the requirements of fire doors and fire safety 4. The administrator and or designee will conduct quarterly rounds ensuring the oxygen storage door meets the fire safety specifications. The audits will be reviewed at the quarterly quality assurance meetings. 5. The above corrective measures will be completed on or before January 2, 2014.</p>	01/02/2014			

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	were no records available to indicate the metal door had a forty five minute fire resistance rating. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/04/13 at 3:30 p.m. 3.1-19(b)				

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K010160 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sprinklered elevator equipment rooms for 2 of 2 elevators in the facility were provided with an automatic means for disconnecting the main line power supply. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main line power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect 12 residents who use the basement therapy room, located across the corridor from the elevator equipment room.</p> <p>Findings include:</p> <p>Based on observation of the basement elevator equipment room on 10/03/13 at</p>	K010160	<p>1. As of 11/7/2013 two contractors have meet with the facility administrator. Quotes will be presented to the administrator by 11/15/13. Once approved, the electrical component of the deficient practice will be complete by 12/31/2013. In addition, the elevator company will order the parts necessary to bring both elevators into compliance with the fire code. The elevator company states the earliest the elevators would be 100% complaint is 3/15/2013. Rounds were conducted to ensure no further issues were needing addressed.</p> <p>3. The maintenance staff was in-serviced on the requirements of elevators and how they relate to fire code requirements. 4. The administrator and or designee will conduct quarterly rounds ensuring the elevators meet the fire safety specifications. The audits will be reviewed at the quarterly quality assurance meetings. 5. The above corrective measures will be completed on or before April 3/2014. A waiver request is attached.</p>	04/03/2014			

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	<p>1:10 p.m. with the maintenance supervisor and administrator, the elevator equipment room was provided with sprinkler coverage. Based on an interview and observation of the main elevator electrical equipment in the basement elevator equipment room on 10/03/13 at 1:30 p.m. with the maintenance supervisor and administrator, there was no indication in the basement elevator equipment room a shunt trip was provided for each elevators' electrical equipment. The lack of a shunt trip to automatically disconnect the main line power supply while sprinklers were activated serving both elevators was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 10/04/13 at 3:30 p.m.</p> <p>3.1-19(b)</p>				