

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 03/19/2013
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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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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: 03/19/13</p> <p>Facility Number: 000016 Provider Number: 155042 AIM Number: 100291500</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>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.</p> <p>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, spaces open to the corridors, and all resident sleeping rooms. The</p>	K010000		

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>facility has a capacity of 170 and had a census of 120 at the time of this survey.</p> <p>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.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/21/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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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 1 of 1 ceiling smoke barriers provided at least a 30 minute fire resistance rating. LSC 8.3.2 requires smoke barriers to extend from an outside wall to an outside wall. This deficient practice could affect laundry and kitchen staff, as well as 26 residents in the D Hall, plus any number of the 80 residents from the A, B, C, and D Halls while around the south Nurses' Station which is near the Mechanical Room.</p> <p>Findings include:</p> <p>Based on observations on 03/19/13 between 10:30 a.m. and 1:15 p.m. during a tour of the facility with Maintenance Assistant # 1 and Administrator In Training (AIT), the following rooms were not provided with ceiling smoke barriers with at least a 30 minute fire resistance rating:</p>	K010025	<p>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 April 18, 2013 to the Life Safety Code Recertification Survey conducted on March 19, 2013</p> <p>K025 It is the practice of Willow Manor to assure that ceiling smoke barriers provide at least a 30 minute fire resistance rating. <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> There are no specific residents identified. The areas identified in</p>	04/18/2013			

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	<p>a. The Laundry Room had three pipes penetrating through the ceiling with no fire stopping material. There were one fourth inch to one inch gaps around each pipe.</p> <p>b. The south kitchen had five water pipes penetrating through the ceiling with expandable foam around each pipe. Maintenance Assistant # 1 indicated there was no documentation available to show the expandable foam was an approved fire stop material.</p> <p>c. The D Hall Biohazard closet had a one inch round hole through the ceiling with no fire stopping material.</p> <p>d. The Mechanical Room near the south Nurses' Station had three conduit penetrations through the ceiling with no fire stopping material. There were one half inch to one inch gaps around each conduit. Maintenance Assistant # 1 and the AIT acknowledged the lack of fire stopping material around each ceiling penetration at the time of each observation.</p> <p>3.1-19(b)</p>		<p>the 2567 including the laundry room, the D Hall biohazard closet, and the mechanical room near the south nurses' station have all been repaired with stopping material. The south kitchen has been repaired with fire stop material. Please see under systems implemented to assure compliance with this tag.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Potentially all residents could be effected. The building has been inspected by maintenance to assure that no additional areas exist that may need repair. Please refer to systems implemented to assure compliance with this tag.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>The maintenance department has been in-serviced related to assuring that there are appropriate barriers with 30 minute resistant ratings. As part of the preventive maintenance plan, areas throughout the building will be reviewed monthly to assure that appropriate fire stopping material is around each ceiling penetration. In addition, the preventive maintenance schedule will assure that any area that utilizes expandable foam around piping has the appropriate documentation related to approved fire rating.</p> <p>The corrective action taken to</p>				

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			<p>monitor performance to assure compliance through quality assurance is:</p> <p>Proper fire barriers will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that fire barriers are in place in all required areas. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed: April 18, 2013</p>		

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K010038 SS=B	<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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 doors to the courtyard was provided with a sign indicating "NO EXIT". 7.10.8.1 requires any door, passage, or stairway that is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. Such sign shall have the word NO in letters 2 inches high with a stroke width of 3/8 inch and the word EXIT in letters 1 inch high, with the word EXIT below the word NO. This deficient practice could affect any of the 26 residents, as well as staff and visitors in the D Hall.</p> <p>Findings include:</p> <p>Based on observation on 03/19/13 at 11:45 a.m. during a tour of the facility with Maintenance Assistant # 1 and the Administrator In Training (AIT), the door from the D Hall lounge to the courtyard was not provided with a sign stating "NO EXIT". There was a gate from the courtyard which lead to a parking lot, however, the gate was not marked as an exit. During an interview at the time of observation, Maintenance Assistant # 1</p>	K010038	<p>K038</p> <p>It is the practice of Willow Manor to assure that all exit doors are properly identified.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>There are no specific residents identified. A NO Exit sign has been installed by the door in the D Hall lounge area. Please see under systems implemented to assure compliance with this tag.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>The maintenance staff has been in-serviced related to assuring exit areas are marked with signs in accordance with the regulation. Exit signs including placement and functioning are part of the preventive maintenance schedule. Please see below for means of monitoring.</p> <p>The corrective action taken to monitor performance to assure</p>	04/18/2013			

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	said the door from the D Hall lounge to the courtyard was not marked as, or used as, an exit from the lounge. 3.1-19(b)		compliance through quality assurance is: Exit signs in the building will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that exit signs are in place and functioning properly in the required areas. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed. The date the systemic changes will be completed: April 18, 2013		

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K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Life Safety Manual on 03/19/13 at 9:10 a.m. with Maintenance Assistant # 1 and the Administrator In Training (AIT) present, three of four second shift (evening) fire drills were performed between 2:36 p.m. and 3:38 p.m. During an interview at the time of record review, Maintenance Assistant # 1 acknowledged the times the second shift fire drills were performed.</p> <p>3-1.19(b)</p>	K010050	<p>K050 It is the practice of Willow Manor to assure that fire drills are held at varied times during each shift. The correction action taken for those residents found to be affected by the deficient practice include: There are no specific residents identified. The times related to fire drills have been revised to assure variance on each of the designated shifts. Please see under systems implemented to assure compliance with this tag. 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: The maintenance department has been in-serviced related to fire</p>	04/18/2013			

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			<p>drills. The in-service includes assuring that times are varied on the required shift. The administrator will work with the maintenance department to assure compliance related to varied times in the regulations.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>Fire Drills are monitored as part of the preventive maintenance review at the quarterly QA meetings. Specific review at the designated meetings will include observations of time variance within the designated shifts related to the fire drills. The Maintenance Director, or designee, will be responsible for assure that fire drills are held correctly in accordance with the regulation. Any issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed: April 18, 2013</p>		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide an automatic sprinkler system which provided complete coverage in 1 of 3 smoke compartments in the lower level. This deficient practice could affect 50 residents or more plus Physical Therapy staff.</p> <p>Findings include:</p> <p>Based on observation on 03/19/13 at 12:45 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Administrator In Training (AIT), the elevator equipment room was not provided with sprinkler coverage. This was acknowledged by Maintenance Assistant # 1 and the AIT at the time of observation.</p>	K010056	<p>K056</p> <p>It is the practice of Willow Manor to assure that the regulations related to sprinkler coverage is in compliance.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>There are no specific residents identified. The elevator equipment room is now provided sprinkler coverage. Please see under systems implemented to assure compliance with this tag.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag.</p> <p><i>The measures or systematic changes that have been put into</i></p>	04/18/2013			

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	3.1-19(b)		<p>place to ensure that the deficient practice does not recur include:</p> <p>An in-service has been conducted related to assuring that there is sprinkler coverage in required areas. The Maintenance department is responsible for assuring that the regulations related to sprinkler coverage is in compliance.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>Proper sprinkling of the building will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that sprinklers are in place and functioning properly in the required areas. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed: April 18, 2013</p>		

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K010062 SS=B	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 1000 sprinkler heads was in the proper orientation (upright, pendent, or sidewall). NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is in the improper orientation. This deficient practice could affect 50 residents or more plus Physical Therapy staff.</p> <p>Findings include:</p> <p>Based on observation on 3/19/13 at 12:50 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Administrator In Training (AIT), the sprinkler head in the room behind the elevator was an upright sprinkler head installed on the bottom of the sprinkler pipe instead of a pendent type sprinkler head. This was acknowledged by Maintenance Assistant # 1 and the AIT at the time of observation.</p>	K010062	<p>K062</p> <p>It is the practice of Willow Manor to assure that the regulations related to sprinkler type is in compliance.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>There are no specific residents identified. The sprinkler head in the room behind the elevator has been changed and replaced with the appropriate type of sprinkler. Please see under systems implemented to assure compliance with this tag.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The Maintenance Department has been in-serviced related to assuring that the appropriate type of sprinkler heads are in place according to the regulations. The maintenance department is responsible for assuring that the</p>	04/18/2013			

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	3.1-19(b)		<p>proper type of sprinkler head in the proper orientation is present.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>Proper sprinkling (including orientation of sprinkler head) of the building will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that proper sprinkler head types are in place and functioning properly in the required areas. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed: April 18, 2013</p>		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 1 of 7 fuel fired water heaters had a current inspection certificate to ensure the water heater was 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 any number of the 80 residents from the A, B, C, and D Halls while around the south Nurses' Station which is near the Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation on 03/19/13 at 12:00 p.m. during a tour of the facility with Maintenance Assistant # 1 and the Administrator In Training (AIT), the one hundred gallon fuel fired water heater in the Mechanical Room near the south Nurses' Station had an installation date on the water heater tank of 01/16/12. There was no certificate of inspection available. During an interview at the time of observation, Maintenance Assistant # 1 acknowledged there was no certificate of inspection available.</p>	K010130	<p>K130</p> <p>It is the practice of Willow Manor to assure that the fuel fired water heaters are inspected in accordance with the regulation.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>There are no specific residents identified. Please see under systems implemented to assure compliance with this tag.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Potentially all residents could be effected. Please refer to systems implemented to assure compliance with this tag.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>The fuel fired water heater that was identified in the 2567 is scheduled to be inspected. A letter was received by the Division of Fire and Building Safety indicating that they are aware of our request but that they will be 2-4 weeks out before they can come inspect. The maintenance department has been in-serviced related to assuring that the fuel fired water heaters are inspected in correlation with the regulations.</p> <p>The corrective action taken to monitor performance to assure</p>	04/18/2013			

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 03/19/2013
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	3.1-19(b)		<p>compliance through quality assurance is:</p> <p>Fuel fired water heaters will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring that the fuel fired water heaters are inspected in accordance with the regulations. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed:</p> <p>April 18, 2013 (this date of completion is contingent upon the Division of Fire and Building Safety division arriving to do the inspection in the next 3 weeks.)</p>		

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to maintain an electric outlet in 1 of 18 smoke compartments. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice could affect one dietary staff person while in the Dietary Office.</p> <p>Findings include:</p> <p>Based on observation on 03/19/13 at 10:42 a.m. during a tour of the facility with Maintenance Assistant # 1 and the Administrator In Training (AIT), the electric outlet in the Dietary Office was missing the cover or faceplate. This was acknowledged by Maintenance Assistant # 1 and the AIT at the time of observation.</p> <p>3.1-19(b)</p>	K010147	<p>K147</p> <p>It is the practice of Willow Manor to assure that all electrical outlets have covers or faceplates.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>There are no specific residents identified. The cover to the electrical outlet in the dietary office has been corrected. Please see under systems implemented to assure compliance with this tag.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>Potentially all residents could be effected. Building wide, the building has been assessed to assure covers are on all electrical outlets. Please refer to systems implemented to assure compliance with this tag.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>The maintenance department has been in-serviced related to assuring that there are electrical outlet covers or faceplates on every outlet. Please see below for means of monitoring.</p> <p>The corrective action taken to monitor performance to assure compliance through quality</p>	04/18/2013	

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			<p>assurance is:</p> <p>Covering or faceplates for electrical outlets in the building will be monitored as part of the preventive maintenance review at the quarterly QA meetings. The Maintenance Director, or designee, will be responsible for assuring all electrical outlets are covered appropriately. Any identified issues will be immediately addressed. The Administrator, or designee, will review the preventive maintenance documentation quarterly for compliance with recommendations as needed.</p> <p>The date the systemic changes will be completed:</p> <p>April 18, 2013</p>		