

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155139	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2014
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NAME OF PROVIDER OR SUPPLIER  NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
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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: 04/08/14</p> <p>Facility Number: 000064 Provider Number: 155139 AIM Number: 100288770</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, North Woods Village 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 two story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors. The resident rooms have battery powered smoke detection. The facility has a capacity of 164 and had a census of 148 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for the two detached</p>	K010000	<p>April 22, 2014</p> <p>Ms. Kim Rhoades, Director</p> <p>Indiana State Department of Health</p> <p>2 North Meridian St.</p> <p>Indianapolis, Indiana 46204</p> <p>Dear Ms. Rhoades:</p> <p>Please accept this 2567 Plan of Correction for the Life Safety Code Survey ending April 8, 2014, as our Letter of Credible Allegation. We also respectfully request Desk Review in lieu of a post survey revisit on or after May 8, 2014</p> <p>Thank you for your time in reviewing our plan of correction and please call with any questions.</p>	

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>garages for facility storage and a shed.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>		<p>Sincerely,</p> <p>Cathy S. Greene</p> <p>Executive Director</p> <p>North Woods Village</p>	

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K010018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are		<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any; conclusion set forth in the statement of deficiencies or of any violation of regulation.</p> <p>This provider respectfully request that the 2567 plan of correction be considered the letter of credible allegation and respectfully request desk review in lieu of a Post Survey Review on or after 5-8-14.</p>		

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	<p>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.</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 sets of double leaf corridor doors could latch independently into their door frames. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 04/08/14 during the tour between 12:00 p.m. and 3:00 p.m. with the Maintenance Supervisor, the following sets of double leaf corridor doors required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame:</p> <ol style="list-style-type: none"> <li>First floor, kitchen on service hall</li> <li>First floor, entrance to main dining room on dining hall</li> <li>First floor, activities room next to elevator</li> <li>Second floor, three sets of double leaf doors in memory care, Walnut hall</li> </ol> <p>Based on interview on 04/08/14 with the Maintenance Supervisor, it was acknowledged he was unaware the aforementioned corridor doors needed to</p>	K010018	<p><b>K018</b></p> <p>It is the practice of this provider to ensure that the doors protecting openings, exits, or hazardous areas are substantial doors and are provided with a means suitable for keeping the door closed to meet LSC requirements.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*The first floor double leaf doors at kitchen service hall, entrance to main dining room, and activity room and second floor three sets of double leaf doors in Memory care and Walnut hall have independent latches installed on doors to meet the LSC requirement on 4-11-14 by Maintenance Supervisor.</p>	05/08/2014

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	<p>latch independently into their door frame.</p> <p>3.1-19(b)</p>		<p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*All other doors assessed for independent latches and installed as needed on 4-11-14 by Maintenance Supervisor</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?</b></p> <p>*Maintenance will monitor latching of doors to ensure proper latching and working order with preventive maintenance schedule.</p> <p>*Reviewed other potential areas and have repaired these areas as needed with independent latches to meet LSC Standards on 4-11-14 by Maintenance Supervisor</p>	

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K010021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p>		<p><b>How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <p>*Monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur by Maintenance Director.</p> <p>*Maintenance Director is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 5-8-14</p>	
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	<p>Based on observation and interview, the facility failed to ensure 1 of 8 corridor doors serving hazardous areas such as rooms containing combustible items was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect 22 residents on Willow Lane hall second floor as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/08/14 at 1:05 p.m. with the Maintenance Supervisor, the nursing supply room storing thirty four cardboard boxes at the second floor nursing station was held open by a string and coat hanger hooked to the doorknob which would not allow the door to close. Based on interview on 04/08/14 at 1:07 p.m. it was acknowledged by the Maintenance Supervisor, the aforementioned storage room door was held open as described so the door could not close.</p> <p>3.1-19(b)</p>	K010021	<p><b>K021</b> It is the practice of this provider to ensure that one hour fire rated construction ¾ fire rated doors have self closures to protect hazardous areas .</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*The string and coat hanger were removed immediately on 4-8-14 by Maintenance Supervisor.</p> <p>*Staff was inserviced on keeping doors closed and not propping open at any time on 4-8-14 and again on 4-15-14 by Staff Development Coordinator (SDC) or designee.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>*All residents have the potential to be affected by the alleged deficient practice.</p> <p>*All other doors in facility were assessed on not being held open on 4-8-14 by Maintenance Supervisor.</p>	05/08/2014	

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			<p>*The string and coat hanger were removed immediately on 4-8-14 by Maintenance Supervisor.</p> <p>*Staff was inserviced on keeping doors closed and not propping open at any time on 4-8-14 and again on 4-15-14 by Staff Development Coordinator (SDC) or designee.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?</b></p> <p>*All hazardous area doors have been assessed to ensure all have appropriate self closures and were not propped open per Life Safety Code (LSC) by maintenance Supervisor by 4-8-14</p> <p>*Maintenance Supervisor will monitor with monthly preventive maintenance schedule and on daily rounds of facility.</p> <p>*Staff was inserviced on keeping doors closed and not propping open at any time on 4-8-14 and again on 4-15-14 by Staff Development Coordinator (SDC) or designee.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p>	

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 2 doors on Birch Lane and 1 of 1 doors on Magnolia Lane which led to hazardous areas such as rooms with combustible items were provided with self closing devices which would cause the doors to automatically close and latch into the</p>	K010029	<p>*Monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur.</p> <p>*Maintenance Director is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 5-8-14.</p> <p><b>K29</b> It is the practice of this provider to ensure that one hour fire rated construction ¾ fire rated doors have self closures to protect hazardous areas .</p> <p><b>What corrective actions will be</b></p>	

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	<p>door frame. This deficient practice affects 14 residents on Birch Lane and 20 residents on Magnolia Lane as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/08/14 at 1:55 p.m. with the Maintenance Supervisor, the ancillary supply room on Birch Lane containing forty four cardboard boxes inside the room and the file room (room 250) on Magnolia Lane which were both greater than fifty square feet in size, each did not have a self closing device on the corridor door. Based on interview on 04/08/14 at 1:58 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned doors leading into storage rooms containing combustible items were not equipped with self closing devices on the doors.</p> <p>3.1-19(b)</p>		<p><b>accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*Doors identified on Birch Lane and Magnolia Lane had self closures installed by 4-11-14.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>*All residents have the potential to be affected by the alleged deficient practice.</p> <p>*Doors identified on Birch Lane and Magnolia Lane had self closures installed by 4-11-14.</p> <p>*All other doors which led to Hazardous areas were assessed and Self closures were installed as needed by 4-11-14.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?</b></p>		

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			<p>*All hazardous area doors have been assessed to ensure all have appropriate self closures per Life Safety Code (LSC) by maintenance. Supervisor by 4-11-14</p> <p>*Maintenance Supervisor will monitor with monthly preventive maintenance schedule.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur?</b></p> <p>*Monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur.</p> <p>*Maintenance Director is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 5-8-14</p>	

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K010056 SS=F	<p><b>NFPA 101</b> <b>LIFE SAFETY CODE STANDARD</b> 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 ensure 1 of 1 steel armover sprinkler pipes observed on Willow Lane was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/08/14 at 2:15 p.m. with the Maintenance Supervisor, a steel sprinkler pipe armover measured thirty six inches in length and was unsupported. Based on interview on 04/08/14 concurrent with the observation with the Maintenance</p>	K010056	<p>K056</p> <p>It is the practice of this provider to ensure that complete automatic sprinkler system is installed in accordance with LSC standards.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*Identified steel armover sprinkler pipe on Willow Lane was supported properly and armover was placed at 24 inches per Life Safety Code Standards (LSC) by Maintenance Supervisor by 4-11-14.</p>	05/08/2014

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	Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armovert exceeded twenty four inches in length and was unsupported.  3.1-19(b)		<p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*Identified steel armovert sprinkler pipe on Willow Lane was supported properly and armovert was placed at 24 inches per Life Safety Code Standards (LSC) by Maintenance Supervisor by 4-11-14.</p> <p>*All sprinklers have been checked to ensure proper armovert length and support per LSC standards by Maintenance Supervisor by 4-11-14</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur.</b></p> <p>*All sprinklers have been checked to ensure proper armovert length and support per LSC standards by Maintenance Supervisor by 4-11-14.</p> <p>*Will be monitored per monthly Preventive Maintenance Schedule.</p>	

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K010147 SS=E	<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 ensure 1 of 1 extension cords was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 8 residents observed on</p>	K010147	<p><b>How will the corrective action be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?</b></p> <p>*Monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur.</p> <p>*Maintenance Director is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 5-8-14</p> <p>K147 It is the practice of this provider to ensure that extension cords are not used as a substitute for fixed wiring.</p> <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155139	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/08/2014
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NAME OF PROVIDER OR SUPPLIER  NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901
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	<p>service hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/08/14 at 2:11 p.m. with the Maintenance Supervisor, an extension cord used in the kitchen on service hall was connected to an outlet on the north wall to power a fan. Based on interview on 04/08/14 at 2:12 p.m. it was acknowledged by the Maintenance Supervisor, an extension cord was used to provide power to the aforementioned appliance and it was mentioned extension cords were not allowed in the facility.</p> <p>3.1-19(b)</p>		<p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*Extension cords in kitchen for the fan has been removed and appropriate power supply put in place by Maintenance Supervisor 4-8-14.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice.</p> <p>*Extension cords in kitchen for the fan and Therapy department for a computer have been removed and appropriate power supply put in place by Maintenance Supervisor 4-8-14.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur.</b></p> <p>*All other areas using power were assessed for extension cords by 4-9-14</p>	

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			<p>by Maintenance Supervisor.</p> <p>*All areas using power will be monitored for extension cords per monthly Preventive Maintenance Schedule.</p> <p><b>How will the corrective action be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?</b></p> <p>*Monthly preventive maintenance schedule and CQI "Life Safety Review" tool will be used weekly x 4, monthly x 3 and quarterly up to 6 months to monitor so deficient practice does not recur.</p> <p>*Maintenance Director is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 5-8-14</p>	

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