

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 07/09/2012
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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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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/09/12</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</p>	K0000	<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. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</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>Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident rooms. The facility has a capacity of 90 and had a census of 45 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0018 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.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 58 basement and first floor corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects any residents using the basement therapy gym and residents who reside in the same smoke compartment as resident room 102.</p> <p>Findings include:</p> <p>Based on observation on 07/09/12 during a tour of the facility from 10:00 a.m. to 4:30 p.m. with the administrator and maintenance supervisor, the door to the forty square foot storage room next to the oxygen storage room located in the basement lacked latching hardware, and the door to resident room 102 failed to</p>	K0018	<p>K018 Requires the facility to ensure that doors will latch and resist the passage of smoke with no impediment to closing the doors. The facility will ensure this requirement is met through the following: 1. No residents were harmed. 2. All residents have the potential to be affected. The doors to the forty foot storage room and room 102 was repaired. 3. The maintenance supervisor was made aware the importance of ensuring that all doors latch. 4. The administrator will monitor to ensure that the doors are able to latch weekly times three months. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly. 5. The above corrective measures will be completed on or before July 20th,</p>	07/20/2012			

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	latch into the door frame leaving a one inch gap along the latching side of the door. The basement storage room door lacking latching hardware and the door to resident room 102 failing to latch into the door frame was acknowledged by the administrator and maintenance supervisor at the time of observations. 3.1-19(b)		2012.		

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K0025 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 3 of 28 basement room wall and ceiling smoke barriers, 1 of 33 first floor wall smoke barriers, and 1 of 25 second floor wall smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects any resident using the basement therapy gym, 16 residents who reside on the first floor West Hall, and 16 residents who reside on the second floor West Hall.</p> <p>Findings include:</p> <p>Based on observations with the administrator and maintenance supervisor on 07/09/12 during a tour of the facility from 10:00 a.m. to 4:30 p.m., the following smoke barrier walls had penetrations which were not fire stopped or were missing drywall:</p>	K0025	<p>K025 Requires the facility to ensure smoke barrier walls are at least a one half hour fire resistance rating. The facility will ensure this requirement is met through the following:1. No residents were harmed.2. All residents have the potential to be affected. The water heater room, the basement sewer lift station room and the basement housekeeping storage room ceiling were repaired. The first and second floor janitor's room walls were repaired as well.3. The maintenance supervisor was educated on the importance of having smoke barrier walls are at least a one half hour fire resistance rating.4. The administrator will conduct an audit to ensure that all ceilings and walls are repaired to ensure that are a one half hour fire resistance rating weekly times three months.5. The above corrective measures will be completed on or before July 20th,</p>	07/20/2012			

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	<p>a. The basement water heater room ceiling had a two foot by two foot section of mortar missing on the southeast corner of the concrete ceiling where sewer and water piping penetrated to the floors above with no fire stopping material, and a one foot by two foot section of mortar missing in the concrete ceiling near the door where electrical conduit penetrated the ceiling which was not fire stopped, with visible concrete mortar broken and falling onto the concrete floor.</p> <p>b. The basement sewer lift station room ceiling had a three foot by two foot section of drywall which was rotted and falling down from the ceiling above the sewer lift station pump.</p> <p>c. The basement housekeeping storage room had a one inch gap in the concrete ceiling around a four inch sewer pipe penetration which was not fire stopped.</p> <p>d. The first floor janitor room on the West Hall had a four foot by three foot section of drywall missing on the north wall.</p> <p>e. The second floor janitor room on the West Hall had a four foot by three foot section of drywall missing on the north wall.</p> <p>The administrator and maintenance supervisor at the time of observations acknowledged the aforementioned basement, first floor, and second floor ceiling and wall penetrations were not</p>		2012.	

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	<p>firestopped or were missing drywall.</p> <p>3.1-19(b)</p>			

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K0143 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 oxygen storage/transfer locations was provided with a mechanical ventilation. This deficient practice affects any residents using the basement therapy gym.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance supervisor on 07/09/12 at 10:30 a.m., the basement liquid oxygen storage room where eight full liquid oxygen containers were stored lacked mechanical ventilation. Based on an interview with the administrator on 07/09/12 at 10:50 a.m., nursing staff transfer liquid oxygen into small portable oxygen containers in the liquid oxygen</p>	K0143	<p>K143 Requires the facility to ensure that oxygen storage/transfer locations are provided with a mechanical ventilation. The facility will ensure this requirement will ensure this requirement is met through the following:1. No residents were harmed2. All residents have the potential to be harmed. The oxygen room had mechanical ventilation placed in it. A fan was placed in the room.3. The maintenance supervisor was educated on the importance of having mechanical ventilation in an oxygen storage/transfer location.4. The administrator will ensure that mechanical ventilation is provided in the oxygen storage room weekly times three months.5. The above corrective measures will be completed on or before July 20th,</p>	07/20/2012			

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	<p>storage room and it appears from the one foot by two foot opening in the west wall, the room had a vent at one time. The lack of mechanical ventilation was acknowledged by the administrator at the time of observation.</p> <p>3.1-19(b)</p>		2012.		