STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 01 / B. WING	06/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 06/08/14 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this Life Safety Code survey, Woodland 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. This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor and battery operated smoke detectors in the resident rooms. The facility has a capacity of 80 and had a census of 57 at the time of this survey.	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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K 0025 SS=D Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 4 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or 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 occupants.	K 0025	K025 Corrective action: Penetrations in attic wall near room 116, entrance to Chall, near room 400 and in environmental office have been properly firecaulked. Penetrations in maintenanceoffice and unit 4 clean utility have been properly fire caulked. Identifying others at risk: Maintenance Supervisors will inspect/audit all areas in theattic around fire doors to ensure no other penetrations are present. Preventative measures in place: Maintenance Supervisor will add audit to preventativemaintenance program to check fire wall areas monthly for any newpenetrations. Any penetrations foundwill be corrected to ensure proper fire / smoke barrier is intact.	07/08/2015

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	Findings include: Based on observations with Maintenance Director on 06/08/15 from 3:00 p.m. to 3:22 p.m., the following smoke barrier walls had unsealed penetrations or penetrations sealed with an unrated material: a) In the attic of the smoke barrier wall near resident room 116 there was a two inch penetration around internet cables. Additionally, a paper towel was used to seal two penetrations and was stuffed in the gap between the smoke barrier wall and the roof. b) In the attic of the smoke barrier wall entering c hall there was a two inch penetration around conduit and a one fourth inch penetration around conduit. c) In the attic of the smoke barrier wall near resident room 400 fiberglass insulation was stuffed into the gap where the smoke barrier wall meets the corrugated roof. d) In the attic of the smoke barrier wall near the Director of Environmental Services office there was a three inch penetration and one half inch penetration around conduit This was acknowledged by the Maintenance Supervisor at the time of observations.		Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on an observation and interview on 06/08/15 at 11:55 a.m., the Maintenance Director acknowledged there was a two inch unsealed penetrations in the ceiling of the maintenance office. At 12:35 p.m., the Maintenance Director acknowledged there were a one half inch and a one eight inch unsealed ceiling penetration around two conduits in the unit 4 clean utility room. 3.1-19(b)			
K 0038 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 1 unit 2 exit doors and 1 of 1 unit 2 exit discharge	K 0038	K038 Corrective action: Corrected code has been inputted	07/08/2015

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	paths was readily accessible and unobstructed at all times. This deficient practice could affect at least 10 residents in unit 2. Findings include: a. Based on observation with the Maintenance Director on 06/08/15 at 1:25 p.m., the magnetic locking device did not release when the numbers provided by the posted code were entered into the keypad. Based on an interview at the time of observation, the Maintenance Director acknowledged the code provided was incorrect. b. Based on observation with the Maintenance Director on 06/08/15 at 1:23 p.m., in the sidewalk at the unit 2 exit discharge there was a sewer clean out. Based on interview at the time of observation, the Maintenance Director confirmed the six inch sewer clean out cover was missing creating a trip hazard in the sidewalk of the unit 2 discharge path. 3.1-19(b)		into the magnetic lockingdevice to provide proper release when code is entered on key pad. A new cover has been installed on exteriorsewer clean out to eliminate trip hazard. Identifying others at risk: Maintenance Supervisor will complete an audit of all keypads on magnetic locking devices to ensure correct releasing of the magneticlocking device when code is entered on key pad. Maintenance Supervisor willcomplete an audit of all exterior sewer clean outs to ensure proper covers arein place. Preventative measures in place: Maintenance Supervisor or designee will check weekly for 60days the function of the key pads on all magnetic locking devices to ensureproper release when code is entered. Ifaudit shows 100% compliance audit will be discontinued. Maintenance Supervisor will inspect weeklyfor 30 days the placement of sewer clean out covers. If audit shows 100% compliance audit willdiscontinued. Monthly checks will be continued as part of the preventativemaintenance program. Quality Assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	
K 0045	NFPA 101			

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SS=E Bldg. 01	LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to provide continuous illumination for 1 of 1 Alzheimer's unit exit discharges that could not be controlled by light switches. LSC Sections 7.8 requires continuous illumination during the time the conditions of occupancy require the means of egress be available for use. This deficient practice could affect at least 6 residents in the Alzheimer's unit. Findings include: Based on an observation with the Maintenance Director on 06/08/14 at 12:05 p.m., the emergency powered exterior light was controlled by a corridor light switch at the Alzheimer's unit exit. At the time of observations, the Maintenance Director confirmed the exterior exit light was controlled by a light switch. 3.1-19(b)	K 0045	K045 Corrective action: Exterior exit light has been changed from a switch operationto emergency power connection. Identifying others at risk: Maintenance Supervisor will audit all exterior exit lights,any lights found not properly connected will be corrected. Preventative measures in place: Maintenance Supervisor will add the inspection of exteriorexit lighting to the preventative maintenance program. Maintenance Supervisor or designee will auditexterior exit lighting weekly for 60 days to ensure proper function. If audit shows 100% compliance audit will bediscontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	07/08/2015
K 0050	NFPA 101			

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SS=F Bldg. 01	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			
	Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Fire Drill Report" with the Maintenance Director on 06/08/15 at 10:59 a.m., there was no record of a third shift and a first shift fire drill for the fourth quarter of 2014. Based on an interview at the time of record review, the Maintenance Director was not aware of the quarterly fire drill requirements. 3.1-19(b) 3.1-51(c)	K 0050	K050 Corrective action: Maintenance Supervisor has corrected the deficient recordingof fire drill as of the last quarter of 2014. Fire drills are being properly conducted on each shift quarterly. Identifying others at risk: Maintenance Supervisor will audit first and second quarterfire drill for 2015 to ensure proper timely fire drills were conducted on eachshift. Preventative measures in place: Maintenance Supervisor will audit fire drill log monthly forthe next two quarters to ensure proper fire drills have been completed on eachshift. If audit shows 100% compliance,audit will be discontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	07/08/2015

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K 0051 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 1. Based on observation and interview, the facility failed to ensure 8 of 10 manual fire alarm boxes were mounted at the proper height. NFPA 72, The National Fire Alarm Code, 2-8.1 states the operable part of each manual fire alarm box shall be not less the forty two inches and not more than fifty four inches from the floor level. This deficient practice affects all occupants except staff in the service hall in the event of an emergency. Findings include:	K 0051	K051 Corrective action: All fire alarm boxes that were mounted outside of properheight requirement have been remounted to the proper height. Equipment has been relocated away from firealarm boxes to allow proper access to the pull stations. Identifying others at risk: Maintenance Supervisor will audit all fire alarm boxes toensure that all boxes are mounted at the correct height requirement. Any additional boxes found out of compliancewill be remounted. Staff will be	07/08/2015

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	Based on observations with the Maintenance Director on 06/08/14 from during a tour of the facility from 12:00 p.m. to 3:45 p.m., all manual fire alarm boxes measured fifty nine inches from the floor level with the exception of the two in the service. The Maintenance Director acknowledged and provided the measurements at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 unit 2 manual fire alarm boxes was readily accessible. NFPA 72, The National Fire Alarm Code, 2-8.2.1 states manual fire alarm boxes shall be distributed throughout the protected area so that they are unobstructed, readily accessible, and located in the path of exit from the area. This deficient practice affects at least 10 residents in unit 2. Findings include: Based on observation and interview on 06/08/15 at 1:26 p.m., the Maintenance Director acknowledged the unit 2 manual fire alarm pull station was obstructed by a portable lift.		educated on not blocking access to the firealarm pull stations. Preventative measures in place: Maintenance Supervisor will add to preventative maintenanceprogram the inspection of fire alarm pull stations for proper placement. Maintenance Supervisor or designee will audittwo times weekly for the proper placement / storage of equipment away from firealarm pull stations to ensure stations are not obstructed. If audit shows 100% compliance, audit will bediscontinued. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	

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	3.1-19(b)			
K 0062 SS=D Bldg. 01	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 Based on observation and interview, the facility failed to replace the loaded sprinkler head in 1 of 47 resident rooms and 1 of 1 unit 1 storage closets. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 residents in resident room 225 and facility staff. Findings include: Based on observations on 06/08/14 at 1:54 p.m. and then again at 2:30 p.m., the Maintenance Director acknowledged there was a buildup of paint on the sprinkler head in resident room 225 and the unit 1 storage closet.	K 0062	K062 Corrective action: Sprinkler head in room 225 and unit one storage closet havebeen replaced. Identifying others at risk: Maintenance supervisor will audit all sprinkler heads toensure proper function. Any found to bepainted, corroded, or damaged will be replaced. Preventative measures in place: Maintenance Supervisor will add to preventative maintenanceprogram to check sprinkler heads monthly for signs of paint, corrosion, ordamage that would impair the function of the sprinkler. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	07/08/2015

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	3.1-19(b)			
K 0069 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure the nozzles in 1 of 1 kitchen exhaust system were installed correctly. NFPA 96,1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 9-1.2.2 states, cooking appliances requiring protection shall not be moved, modified, or rearranged without prior reevaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire-extinguishing system. A-9-1.2.2 explains the effectiveness of an automatic extinguishing system is affected by the placement of the nozzles. For this reason, it is essential that cooking appliances be situated in the area in which they were when the extinguishing equipment was designed and installed. If an appliance is moved	K 0069	K069 Corrective action: The spray nozzles identified on the kitchen hood suppressionsystem have been re-aligned to proper coverage of stove. Identifying others at risk: Maintenance Supervisor will inspect all spray nozzles on thekitchen suppression system for proper coverage. Preventative measures in place: Maintenance Supervisor will add inspection of the kitchenhood suppression system to the preventive maintenance program of the kitchen tobe audited monthly. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	07/08/2015

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	from under the equipment for cleaning or any other reason, it should be replaced to its original position prior to initiating a cooking operation. This deficient practice affects at least 15 residents in the main dining room. Findings include: Based on observation with the Maintenance Supervisor on 06/08/15 at 2:22 p.m., the two spray nozzles for the kitchen hood suppression system were pointed towards the floor in front of the gas fuel commercial stove in the kitchen. Based on an interview at the time of observation, the Maintenance Supervisor confirmed the spray nozzles were not positioned to provide coverage for the kitchen stove. 3.1-19(b)			
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors at the opening in the kitchen wall, a hazardous area, was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall	K 0130	K130 Corrective action: Rolling fire door has been inspected by service company forproper function. Identifying others at risk: Maintenance Supervisor will audit all equipment for fireprotection that is maintained or inspected by outside	07/08/2015

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	thereafter be maintained unless the Code exempts such maintenance. 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 at least 15 residents in the main dining room. Findings include: Based on observation with the Maintenance Director on 06/08/15 at 4:00 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on interview at the time of observation, the Maintenance Director was unable to provide a current inspection for the rolling fire door. 3.1-19(b)		service companies forcompliance with proper inspection records. Preventative measures in place: Maintenance Supervisor will add the auditing of fireinspection completion to the preventative maintenance program. Any equipment found to out of compliance willbe referred to the appropriate vendor for service and compliance withinspection timelines. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	
K 0143 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility			

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WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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	wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (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			
	Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any residents near the oxygen transferring room. Findings include: Based on an observation with the Maintenance Director on 06/08/15 at 1:19 p.m., three holes were cut in the first layer of the two layers of drywall on the ceiling of the oxygen transferring room. One hole measured six inches in diameter, the second hole measured four inches in diameter and the remaining was a six inch by six inch square. The Maintenance Director confirmed the	K 0143	K143 Corrective action: The secondary layer of drywall has been replaced with newfire rated drywall to correct the improper openings. Identifying others at risk: Proper correction of drywall will remove the risk toresidents and staff. Preventative measures in place: The Maintenance supervisor will add to the preventative maintenanceprogram to audit the status of the drywall in the oxygen transfer room monthlyto ensure smoke / fire penetration is intact. Quality assurance program in place: All Audit findings will be reviewed monthly at QA Committeemeeting, additional action plan will be put into place to address negativeoutcomes. Compliance 7/8/2015	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155086		06/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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	measurement at the time of observation. 3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw and 2 of 2 multiplug adapters and 2 of 2 extension cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on observations and interview on 06/08/15 from 12:34 p.m. to 2:21 p.m., the Maintenance Director acknowledged the following: a) a multiplug adapter was plugged in and supplying power to a computer and a phone at the unit 4 nurses' station b) a window mounted AC unit was	K 0147	K147 Corrective action: The multi plug adapter at unit 4 nursing station has beenreplaced with a properly protected device. Air conditioner units in the HumanResource and Community Liaison offices have been corrected. Extension cord in the Dietary Manager officehas been eliminated. Identifying others at risk: Maintenance Supervisor will audit all offices and nursesstations for proper electrical use. Equipment found to be improperly connected will be corrected or takenout of service. Preventative measures in place: Maintenance Supervisor will audit offices and nursesstations weekly for 60 days for improper use of the electrical outlets. If audit shows 100% compliance audit will bediscontinued. Maintenance Supervisorwill add to the preventative maintenance program the auditing of offices andnurses stations for electrical compliance ongoing monthly. Quality assurance program in place: All Audit findings willbe reviewed	07/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/08/2015
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514	

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	supplied power by a extension cord power strip in the HR office and the Community Liaison Director's office c) an extension cord was plugged in a receiving power from a multiplug adapter in the Community Liaison Director's office d) an extension cord was plugged in and supplying power to a printer in the Dietary Manager's office. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 electrical receptacle in the front office. 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 was not in a resident care area but could affect facility staff. Findings include: Based on observation and interview on 06/08/15 at 12:55 p.m., the Maintenance Director acknowledged the front office receptacle had a broken plastic face exposing the metal prongs. 3.1-19(b)		monthly at QA Committee meeting, additional action plan will be putinto place to address negative outcomes. Compliance7/8/2015	

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	155086	A. BUILDING 01 B. WING	06/08/2015

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