

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 01/11/2012
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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN46901
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K0000	<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: 01/11/12</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 spaces open to the corridors. The resident rooms have battery operated smoke detection. The facility has a</p>	K0000		

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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K0029 SS=E	<p>capacity of 164 and had a census of 143 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/19/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>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 leading to hazardous areas such as kitchens was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 8 residents observed in the dining room which is next to the Service corridor</p>	K0029	<p>January 25, 2012</p> <p>Kim Rhoades Indiana State Department of Health 2 North Meridian St. Indianapolis, Indiana 46204</p> <p>Dear Kim Rhoades:</p>	02/01/2012

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	<p>where the kitchen is located, as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 01/11/12 at 1:45 p.m. with the Maintenance Supervisor, the door to the kitchen on Service hall next to the dining room was provided with a door closer, but there was no latching device to secure the door in the jamb. Based on interview on 01/11/12 at 1:28 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door leading into the kitchen was not equipped with a latching device to keep the door closed.</p> <p>3.1-19(b)</p>		<p>Please accept this 2567 Plan of Correction for the Life Safety Code Survey ending January 19, 2012 as our Letter of Credible Allegation.</p> <p>Thank you for your time in reviewing our plan of correction and please call with any questions.</p> <p>Sincerely,</p> <p>Cathy S. Greene Executive Director North Woods Village</p> <p>The creation and submission of this plan of correction does not constitute an admission by this provider of any</p>		

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			<p>conclusion set forth in the statement of deficiencies or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post certification review on or after 2-1-2012.</p> <p>K029 It is the practice of this provider to ensure that the a 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.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice. *The door leading to the kitchen been assessed and appropriate latching device to secure the door in the jamb has been installed to meet the LSC requirement.</p> <p>How will you identify other</p>		

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			<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice. *The appropriate latching device was installed to meet LSC requirement.</p> <p>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur?</p> <p>*Identified area has had appropriate installation of latching device to secure the door in the jamb per LSC requirement. *Reviewed other potential areas assessed to ensure these areas meet LSC Standards.</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <p>*The latching device was placed to secure the door in the jamb per LSC Standard and monthly preventive maintenance schedule and Environmental CQI tools will be used to monitor so deficient practice does not recur. *Maintenance Director is responsible for compliance, results will be reported to QA committee</p> <p>Completion Date: 2-1-2012</p>	

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K0056 SS=E	<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 ensure 2 of 2 elevator mechanical rooms were provided with an automatic sprinkler system to ensure sprinkler coverage in all portions of the building. NFPA 13, 5-13.11 lists three exceptions which must be met to maintain a nonsprinklered status in elevator mechanical rooms:</p> <ol style="list-style-type: none"> The room is dedicated to electrical equipment only. Only dry type electrical equipment is used. Equipment is installed in a 2 hour fire rated enclosure including protection for penetrations. No combustible storage is permitted to be stored in the room. <p>This deficient practice could affect 14 residents on north hall and 12 residents on south hall as well as visitors and staff.</p>	K0056	<p>K056</p> <p>It is the practice of this provider to ensure that 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.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>*Residents in the facility have the potential to be affected by the alleged deficient practice. *All areas identified have been reviewed and appropriate fire rating doors have been ordered and will be installed by 2-1-2012 at both Elevator mechanical rooms.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	02/01/2012	

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	<p>Findings include:</p> <p>Based on observations on 01/11/12 during the tour between 1:17 p.m. to 2:20 p.m. with the Maintenance Supervisor, the elevator mechanical rooms on north and south halls were not sprinklered and were not enclosed with a fire rated corridor door. Based on interview on 1/11/12 concurrent with the observations with the Maintenance Supervisor, it was acknowledged a sprinkler head was not present in the elevator mechanical rooms and the corridor doors were not rated for at least ninety minutes to meet exception (c).</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>*All doors have been assessed and the two elevator mechanical room doors will be replaced by 2-1-2012.</p> <p>What measures will be put into place or what systematic changes you will make to ensure deficient practice does not recur.</p> <p>* All doors have been assessed and the two elevator mechanical room doors will be replaced by 2-1-2012. *Will be monitored for proper doors per monthly Preventive Maintenance Schedule.</p> <p>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?</p> <p>*Proper fire rated doors will be replaced by 2-1-2012 per LSC standard. *Will monitor for proper fire rated doors through monthly Preventive Maintenance Schedule and Environmental CQI tool. *Areas will be reviewed by QA committee and Maintenance Director to monitor for compliance.</p> <p>Completion Date: 2-1-2012</p>		