

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155229	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/26/2012
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NAME OF PROVIDER OR SUPPLIER  WOODLANDS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN 47304
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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: 09/26/12</p> <p>Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Woodlands 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 was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with battery powered smoked detectors in all resident sleeping rooms. The facility</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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	<p>has a capacity of 99 and had a census of 89 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one shed and two barns providing storage which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/02/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K0017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 open use areas was separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K0017	<p><b>K 0017WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> A Smoke detector has been installed in the Reception office. <b>HOW WILL OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:</b> All residents have the potential to be affected. A visual inspection was conducted to ensure that other open areas are properly equipped with smoke detectors. <b>WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGE WILL BE MADE TO PREVENT RECURRENCE.</b> Verification of smoke detector placement and proper functioning</p>	10/25/2012			

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	<p>detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect 16 residents adjacent to the Front Reception office by the front entrance as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/26/12 at 12:04 p.m. with the Maintenance Supervisor, the Reception office next to the front entrance had sliding glass windows separating the office from the corridor and was open to the corridor. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview on 09/26/12 at 12:06 p.m. with the Maintenance Supervisor, it was acknowledged the Reception office which was open to the corridor without supervision from the nurse's station was not protected by automatic smoke detection.</p>		<p>will be added to the monthly Preventive Maintenance Program. <b>HOW WILL THE CORRECTIVE ACTION BE MONITORED.</b> The Maintenance Supervisor will submit results of the Preventive Maintenance Audits to the Performance Improvement Committee meeting for inclusion in the Performance Improvement Minutes monthly times 12 months. <b>Supporting documentation has been faxed. DATE COMPLETED 10/25/12</b></p>				

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	3.1-19(b)			

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K0029 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 leading to hazardous areas on Hickory north hall such as rooms with combustible items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 20 residents on Hickory north hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/26/12 at 1:55 p.m. with the Maintenance Supervisor, the central supply room on Hickory north hall had fifty cardboard boxes, the room was greater than fifty square feet in size and was without a self closing device on the corridor door. Based on interview on 09/29/12 at 1:58 p.m. with the Maintenance Supervisor, it was</p>	K0029	<p><b>K 0029WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> A self closing device has been installed on the Central Supply Room door on Hickory Hall. <b>HOW WILL OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:</b> Residents of Hickory Hall have the potential to be affected. A self closing device has been installed. <b>WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGE WILL BE MADE TO PREVENT RECURRENCE.</b> Verification of presence and proper function of self closing devices on doors to hazardous areas will be added to the monthly Preventive Maintenance Program. <b>HOW WILL THE</b></p>	10/25/2012			

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	acknowledged the aforementioned door leading into the central supply room was not equipped with a self closing device on the door.  3.1-19(b)		<b>CORRECTIVE ACTION BE MONITORED.</b> The Maintenance Supervisor will submit results of the Preventive Maintenance Audits to the Performance Improvement Committee meeting for inclusion in the Performance Improvement Minutes monthly times 12 months. <b>DATE COMPLETED 10/25/12</b>		

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K0048 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect 16 residents in the adjacent smoke compartment, as well as staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on record review of the facility's written fire disaster plan on 09/26/12 at 3:45 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use of the K-class fire extinguisher located in the kitchen in</p>	K0048	<p><b>K 0048 WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> The Fire Disaster Plan for this facility was updated in August of 2012 to include the use of K-class fire extinguishers in the kitchen. <b>HOW WILL OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:</b> All residents residing in the facility have the potential to be affected. The current Fire and disaster plan address the use of K-class extinguishers as required. <b>WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGE WILL BE MADE TO PREVENT RECURRENCE.</b> Staff will be re-educated as to the current Fire Disaster Plan and the use of K-class extinguishers by 10/25/12. <b>HOW WILL THE CORRECTIVE ACTION BE MONITORED.</b> The Fire disaster Plan will be reviewed following the annual update completed in July to insure that reference to K-class extinguishers is included. Result of the review will be provided to the Performance</p>	10/25/2012			

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	relationship with the use of the kitchen overhead extinguishing system. Based on an interview on 09/26/12 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the written fire safety plan for the facility did not include mention of the K-class fire extinguisher.  3.1-19(b)		Committee.Supporting documentation has been faxed. <b>DATE COMPLETED 10/25/12</b>		

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K0056 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 ensure a complete automatic sprinkler system was provided for 1 of 4 exits with an outside canopy in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 20 residents on Therapy south hall as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 09/26/12 at 1:35 p.m. with the Maintenance Supervisor, the canopy outside the Therapy south hall</p>	K0056	<p><b>K 0056 WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> Automated sprinkler heads will be added to the canopy outside Therapy south hall. <b>HOW WILL OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:</b> Residents of Therapy south hall have the potential to be affected. An agreement has been executed with Safecare to install automated sprinkler heads to ensure proper coverage. <b>WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGE WILL BE MADE TO PREVENT RECURRENCE.</b> Verification of sprinkler placement and proper</p>	10/25/2012	

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	<p>was attached to the building, extended five feet from the building, was constructed of wood with a vinyl ceiling and asphalt shingles for a roof, and it was not protected with a sprinkler. Based on interview on 09/26/12 at 1:37 p.m. with the Maintenance Supervisor, it was acknowledged there was no sprinkler head present for the canopy outside the Therapy south hall exit to provide complete sprinkler coverage for the facility.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>functioning will be added to the monthly Preventive Maintenance Program. <b>HOW WILL THE CORRECTIVE ACTION BE MONITORED.</b> The Maintenance Supervisor will submit results of the Preventive Maintenance Audits to the Performance Improvement Committee meeting for inclusion in the Performance Improvement Minutes monthly times 12 months. <b>Supporting documentation has been faxed. DATE COMPLETED 10/25/12</b></p>		

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K0066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container specifically for cigarette butts instead of a trash container full of paper goods for 1 of 3 areas where smoking was permitted. This deficient practice could affect 15 residents observed in the Main dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 09/26/12 at 1:05</p>	K0066	<p><b>K 0066 WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> The plastic container has been removed and a non-combustible container with a self closing cover specifically for cigarette butts has been provided in the smoking area. Additionally a non-combustible trash receptacle for disposal of paper and trash only is now present. Each receptacle is clearly labeled for appropriate usage <b>HOW WILL OTHER RESIDENTS HAVING THE POTENTIAL TO BE</b></p>	10/25/2012			

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	<p>p.m. with the Maintenance Supervisor, smoking was permitted just outside the north exit of the Main dining room where over 20 cigarette butts as well as paper goods were observed in a 25 gallon plastic trash container. Based on review of the smoking policy on 09/26/12 at 3:45 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 09/26/12 at 1:10 p.m. with the Maintenance Supervisor, it was acknowledged extinguished cigarette butts were thrown into a plastic container full of paper goods.</p> <p>3.1-19(b)</p>		<p><b>AFFECTED BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:</b> Residents, visitors and staff in the Main Dining room have the potential to be affected. The plastic container has been removed and a non-combustible container with a self closing cover specifically for cigarette butts has been provided in the smoking area. Additionally a non-combustible trash receptacle for disposal of paper and trash only is now present. Each receptacle is clearly labeled for appropriate usage Staff has been re-educated on the proper cigarette disposal. <b>WHAT MEASURES WILL BE PUT IN PLACE OR WHAT SYSTEMIC CHANGE WILL BE MADE TO PREVENT RECURRENCE.</b> Verification of non-combustible container placement and proper usage will be added to environmental rounds done 3 times weekly. Staff will be re-educated on the proper disposal of cigarette butts by 10/25/12 <b>HOW WILL THE CORRECTIVE ACTION BE MONITORED.</b> The Executive Director or designee will conduct environmental audit weekly to ensure proper placement and usage of the non-combustible containers. Audits will be submitted to the Performance Improvement Committee meeting for inclusion in the Performance Improvement Minutes monthly</p>		

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