

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918
---	--

(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	<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: 06/08/15</p> <p>Facility Number: 000323 Provider Number: 155778 AIM Number: 100288440</p> <p>At this Life Safety Code survey, Woodland Manor Nursing Center was found in substantial 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 (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, hard wired smoked detectors in all resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 53 and had a census of 42 at</p>	K 0000	The creation and submission of this plan of correction does not constitute any admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulations. Provider desires that the 2567 plan of correction be considered the letter of credible allegation of the compliance on or after June 26, 2015. Gloria McGowen HFA	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918
---	--

(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 0051 SS=C Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have cutomary access were sprinklered. The facility has one detached garage used for maintenance equipment storage which was not sprinklered.</p> <p>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</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72,</p>	K 0051	Describe what the facility did to correct the deficient practice for each client cited in the deficiency: The fire alarm system	06/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015	
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918			
(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 0056 SS=C Bldg. 01	<p>National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/08/15 at 3:10 p.m., with the Maintenance Supervisor the fire alarm system circuit breaker could not be located. Based on interview on 06/08/15 at 3:15 p.m. with the Maintenance Supervisor it was acknowledged the location of the breaker for the fire alarm panel was unknown.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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,</p>		<p>circuit breaker was located and appropriately labeled inred "Fire Alarm Circuit Breaker". Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state what action(s) the facility took to correct the deficient practice for any client the facility identified as being affected: The Maintenance Supervisor inspected all circuit breakers for correct labeling of the breakers. Describe the steps or systematic changes the facility has made or will make to ensure that the deficient practice does not recur: The Maintenance Supervisor will inspect the circuit breakers for correct identification monthly. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor will report findings to the QA committee for review. By what date the systematic changes will be completed: 6-19-15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918
---	--

(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
--------------------	--	---------------	---	----------------------

	<p>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 7 steel armover sprinkler pipes observed 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 06/08/15 at 1:15 p.m. with the Maintenance Supervisor, the steel sprinkler pipe armover observed exposed and above the window at the north wall of the dining room was at least five feet in length and unsupported.</p> <p>Based on interview on 06/08/15 concurrent with the observation with the Maintenance Supervisor it was</p>	K 0056	<p>Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Safecare repaired the identified steel sprinkler pipe armover that exceeded 24 inches located in the dining room by adding a support. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state what action(s) the facility took to correct the deficient practice for any client the facility identified as being affected: The Maintenance Supervisor and Safecare inspected the entire building to ensure that the armovers to the sprinkler, sprinkler drops, or sprig-ups do not exceed 24 inches for steel pipe or 12 inches for copper tube. Describe the steps or systematic changes the facility has made or will make to ensure that the deficient practice does not recur: The Maintenance Supervisor will inspect the sprinkler pipe armovers monthly and contact SafeCare for any needed repairs. Describe how</p>	06/26/2015
--	--	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918		
(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 0070 SS=B Bldg. 01	<p>acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 1 of 1 portable space heaters observed in non resident rooms. This deficient practice could affect any resident on Administrative hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/08/15 at 1:05 p.m. with the Maintenance Supervisor, one portable space heater was not plugged in, but ready for use in the Receptions office adjacent to the Administrative hall. Based on interview on 06/08/15 concurrent with the observation, it was acknowledged by the Maintenance Supervisor the space heater was not allowed in the facility.</p>	K 0070	<p>thecorrective action(s) will be monitored to ensure the deficientpractice will not recur: TheMaintenance Supervisor shall report findings to the QA committee forreview.By what date thesystematic changes will be completed: 6-26-15</p> <p>Describe what thefacility did to correct the deficient practice for each client cited in the deficiency: All spaceheaters were removed from the building.Describe how thefacility reviewed all clients in the facility that could be affectedby the same deficient practice, and state what action(s) the facilitytook to correct the deficient practice for any client the facilityidentified as being affected: AllStaff in-serviced regarding – space heaters prohibited in thebuilding.Describe thesteps or systematic changes the facility has made or will make toensure that the deficient practice does not recur: TheMaintenance Supervisor will inspect building monthly to ensure thatthere are</p>	06/26/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155778	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2015
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1212 E MAIN ATTICA, IN 47918		
(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	
	3.1-19(b)		no space heaters. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Maintenance Supervisor will report findings to the QA committee for review. By what date the systematic changes will be completed: 6-26-15		