

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  03/01/2012
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NAME OF PROVIDER OR SUPPLIER  WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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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: 03/01/12</p> <p>Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was determined to be of Type II (111) construction and was fully</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>sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor. Currently there are no smoke detectors in the resident rooms. The facility has a capacity of 80 and had a census of 62 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/06/12.</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 Reception offices was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is</p>	K0017	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. An electrically supervised automatic smoke detection system was installed on 3/15/12 in the reception office.</p> <p>IV. The Maintenance Director will check to ensure the smoke</p>	03/30/2012			

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	<p>protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect any residents evacuated through the main entrance in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/01/12 at 2:28 p.m., the Reception office had sliding glass windows in the corridor wall. There was a one half inch gap in between the panes of glass when the window was closed. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the Reception office was not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>detection system is functioning properly weekly for 2 months, bi-weekly for 2 months, monthly ongoing by fire drills. Results are reported to the facility's Quality Assurance Committee for additional recommendations if necessary.</p>	

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K0027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 3 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect four of seven smoke compartments.</p> <p>Finding include:</p> <p>Based on observations with the Maintenance Supervisor on 03/01/12 from 1:25 p.m. to 2:30 p.m., the coordinator failed to</p>	K0027	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. The coordinator was repaired on 3/2/12.</p> <p>IV. The Maintenance Director will check to ensure the coordinator is functioning properly weekly for 2 months, bi-weekly for 2 months, monthly for 2 months and as needed when deemed necessary by the QA committee. Results of all audits are reported to the facility's Quality Assurance</p>	03/30/2012			

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	<p>operate properly preventing the smoke barrier doors near resident room 228 and both sets in the front hall from closing completely, leaving a six inch gap between the doors. This was confirmed by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		Committee for additional recommendations if necessary.				

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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 1 roll down doors at the opening in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect any residents in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/01/12 at 3:40 p.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore, considered to be the corridor wall. There was a pass</p>	K0029	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. The kitchen roll up window has a fire rated counter shutter ordered by 4T Door Systems on 3-13-12 scheduled to arrive the week of March 26, 2012. 4T Door System will "call to schedule installation as soon as it is received". (Faxed confirmation from 4T Door System Attached).</p> <p>IV. The Maintenance Director will</p>	03/30/2012	

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	<p>through opening in the corridor wall between the dining room and the kitchen. The opening was protected with a rolling door. Based on observation with Maintenance Director at 3:45 p.m., the rolling door did not close upon activation of the fire alarm.</p> <p>3.1-19(b)</p>		<p>check to ensure the kitchen roll up window is functioning properly weekly for 2 months, bi-weekly for 2 months, monthly for 2 months and as needed when deemed necessary by the QA committee. Results of all audits are reported to the facility's Quality Assurance Committee for additional recommendations if necessary.</p>		

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K0038 SS=E	<p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 9 doors in the path of egress, equipped with a magnetic locking system, remained unlocked with activation of the building fire protective signaling system. LSC 19.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice could affect any unit 1 residents evacuated through the service hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 03/01/12 at 3:41 p.m., the service hall exit door, which was equipped with a magnetic locking system, failed to remain unlocked</p>	K0038	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. The magnetic locking system was repaired on 3/15/12</p> <p>The exit discharge path was cleared and designated a "no parking" area.</p> <p>IV. The Maintenance Director will check to ensure the area remains clear and designated a "no parking" area ongoing. Results of findings are reported to the facility's Quality Assurance Committee for additional recommendations if necessary.</p>	03/30/2012			

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	<p>when the fire alarm system was placed in silence mode. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 8 exit discharge paths was readily accessible at all times. This deficient practice could affect all residents evacuated through the front unit 2 exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/01/12 at 2:05 p.m., the exit discharge path from the front unit 2 exit lead to the parking lot. At the end of the sidewalk there was a car parked in a parking spot blocking the path of egress to the public way. The parking spot was not designated a "no parking" area. This was acknowledged by the Maintenance Supervisor at the time of observation.</p>						

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	3.1-19(b)				

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K0044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect two of seven smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 03/01/12 at 2:45 p.m., the fire doors near resident room 402 failed to latch into the frame when closed. Based on an interview with the Maintenance Supervisor</p>	K0044	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. The fire doors were repaired on 3/2/12</p> <p>IV. The Maintenance Director will check to ensure the fire door is closing properly weekly for 2 months, bi-weekly for 2 months, monthly for 2 months and as needed when deemed necessary by the QA committee. Results of all audits are reported to the facility's Quality Assurance Committee for additional recommendations if necessary.</p>	03/30/2012			

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	<p>at the time of observation, these doors were confirmed to be fire doors with a fire wall that extends above the roof.</p> <p>3.1-19(b)</p>				

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K0046 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the</p>	K0046	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. The Battery-operated Emergency Lights Test Log was printed from the ISDH Life Safety Code Program website on 3/2/12 and implemented.</p> <p>IV. The Maintenance Director will continue to use the Emergency Lights Test Log for required written record available for review ongoing. Results are reported to the facility's Quality Assurance Committee for additional recommendations if necessary</p>	03/30/2012			

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	<p>Maintenance Supervisor on 03/01/12 at 3:45 p.m., a battery operated emergency task light was observed in the maintenance shop. This light is stored in the maintenance shop and can be magnetically attached to the generator housing in an emergency situation. Based on an interview with the Maintenance Supervisor during the record review process at 12:58 p.m., there were no written records of an annual test or weekly tests for the battery operated emergency task light available for review.</p> <p>3.1-19(b)</p>				

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupant.</p> <p>Findings include:</p> <p>Based on review of the generator log titled "Monthly/Weekly Generator Log" with the Maintenance Supervisor on 03/01/12 at 12:42 p.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not include</p>	K0144	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>I. No residents were identified.</p> <p>II. All residents have the potential to be affected. This has been addressed by the systems described below.</p> <p>III. The Emergency Generator Monthly Test Log was printed from the ISDH Life Safety Code Program website on 3/2/12 and implemented.</p> <p>IV. The Maintenance Director will continue to use the Emergency Generator Monthly Test Log for required written record available for review ongoing. Results are reported to the facility's Quality Assurance Committee for additional recommendations if necessary</p>	03/30/2012			

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  03/01/2012
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	<p>the time for the transfer of power from the main source to the generator. This was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>				

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  03/01/2012
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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 flexible cords and 1 of 1 multiplug adapters were not used as a substitute for fixed wiring to provide power for medical equipment and a window air conditioner. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 8 residents and 1 staff member.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 03/01/12 from 1:20 p.m. to 1:58 p.m., medical equipment was supplied with power by an extension cord power strips near a resident bed in resident rooms 222, 225, 227 (a power strip was plugged into a power strip in resident room 227), and 123 plus</p>	K0147	<p>It is the practice of Woodland Manor to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. I. No residents were identified. II. All residents have the potential to be affected. This has been addressed by the systems described below. III. The extension cord power strips were removed and permanent wiring installed in rooms 222, 225, 227, and 123. All power strips were removed from room 227. The window air conditioner was removed from the MDS Coordinator's office. The three-outlet adapter was removed from room 107. Electrician in and completed projects on 3-12-12. IV. Results are reported to the facility's Quality Assurance Committee for additional recommendations if necessary</p>	03/30/2012

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	<p>a window air conditioner in the MDS Coordinator's office. Additionally, there was a three outlet adapter in use in resident room 107. This adapter allows three items to be plugged into a single outlet. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>			