STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155229	A. BUILDING -- B. WING	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/07/24 Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430 At this Emergency Preparedness survey, The Woodlands was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 108 and had a census of 65 at the time of this survey. Quality Review completed on 03/11/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/07/24 Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430 At this Life Safety Code survey, The Woodlands was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because The Woodlands agrees with the allegations and citations listed. The Woodlands maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Spaugh	Executive Director	03/22/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Subpart 483.90(a), Life Safety from Fire and the 2012 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 VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detection in the resident sleeping rooms. The facility has a capacity of 108 and had a census of 65 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/11/24		compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
K 0211 SS=D Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 3 residents in the corridor by Central Supply.	K 0211	**K211 – Means of Egress** ***What corrective action will be accomplished for those residents found to have been affected by this deficient practice?*** 1 No significant negative outcomes to residents noted	03/23/2024

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	Findings include: Based on an observation during a tour of the facility with the Maintenance Director (MD) on 03/07/24 at 03:10 p.m., the corridor by Central Supply contained a wooden pallet. Based on an interview at the time of observations, the MD agreed there was a wooden pallet stored in the corridor by Central Supply. This finding was reviewed with the Executive Director and MD during the exit conference. 3.1-19(b)		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1 Other residents have the potential to be affected therefore the facility will ensure that delivery pallets are immediately removed from hallways following supply deliveries... ***What measures and what systemic changes will be made to ensure that the deficient practice does not recur:*** 1 Maintenance Director and/or Administrator shall identify, through daily rounds, any item deemed to potentially block a corridor, and immediately remove such items. Additionally, Central Supply associate shall communicate supply delivery dates at daily morning meeting as a means of identifying the potential for wooden pallets being delivered and requiring immediate removal. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place:*** 1 Maintenance Director and/or Administrator will round entire facility weekly X 2mos, every 2 weeks X 2months, and monthly times 2 months to ensure no items are placed/stored in hallways that could prevent safe	

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			passage 2 The results of these rounds/reviews will be discussed at the monthly facility Quality Assurance Performance Improvement (QAPI) meeting monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: March 23, 2024. The Administrator at The Woodlands is responsible for ensuring compliance in this Plan of Correction.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 2 of 8 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet,	K 0232	**K232 – Aisle, Corridor, or Ramp Width** ***What corrective action will be accomplished for those residents found to have been affected by this deficient practice?*** 1 No significant negative outcomes to residents noted ***How other residents having the potential to be affected by the***	03/23/2024

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	except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 25 residents in the Main entrance corridor and Ivy Court. Findings include: Based on observation during a tour of the facility with the Executive Director (ED) and Maintenance Director (MD) on 03/07/24 at 03:25 p.m., four overstuffed chairs in the Main entrance corridor and one Settee in IVY Court corridor extended about two feet into the corridor and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the ED agreed the chairs and settee were not securely attached to the floor or to the wall when tested. These findings were reviewed with the ED and the		***same deficient practice will be identified and what corrective action will be taken:*** 1 Other residents have the potential to be affected therefore the seating identified during the survey has been secured to the wall to avoid movement into the corridor. ***What measures and what systemic changes will be made to ensure that the deficient practice does not recur:*** 1 Maintenance Director and/or Administrator shall identify, through daily rounds, any furniture item deemed to be moveable in such a way to potentially block a corridor, and immediately remove such items until the item(s) can be secured to the wall to prevent movement. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place:*** 1 Maintenance Director and/or Administrator will round entire facility weekly X 2mos, every 2 weeks X 2months, and monthly times 2 months to ensure no items are placed/stored in hallways that could prevent safe passage 2 The results of these rounds/reviews will be discussed at the monthly facility Quality Assurance Performance Improvement (QAPI) meeting	

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	MD during the exit conference. 3.1-19(b)		monthly for a total of 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance date: March 23, 2024. The Administrator at The Woodlands is responsible for ensuring compliance in this Plan of Correction.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 15 residents on Southern Pines Hall and the East Hall.	K 0374	**K374 – Subdivision of Building Spaces – Smoke Barrier Doors** ***What corrective action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 No significant negative outcomes to residents noted	03/23/2024

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	Findings include: Based on observation on 03/07/24 at 02:55 p.m. during a tour of the facility with the Maintenance Director (MD), the set of smoke barrier doors between Southern pines corridor and the East Hall did not close completely due to the west door catching on the other door. There was a one inch gap between the doors when closed to their fullest. Based on interview during the time of observation, the Maintenance Director acknowledged this set of smoke barrier doors did not close completely when tested. This finding was reviewed with the Executive Director and MD at the exit conference. 3.1-19(b)		***How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1 Other residents have the potential to be affected therefore the 1 of 6 doors identified as not fully closing has been adjusted to close per regulation ***What systemic changes will be made to ensure that the deficient practice does not recur:*** 1 Maintenance Director or designee will check all fire doors during facility rounds to ensure proper closure occurs. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place:*** 1 Maintenance Director will check all fire doors weekly times 2 months, every other week times 2 months, and then monthly times 2 months and then quarterly thereafter once compliance is at 100%. Results will be reported at the facility Monthly QAPI meeting. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **Compliance Date: March 23, 2024. The Administrator at The Woodlands is responsible for ensuring compliance in this plan of correction.**	

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K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 4 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director (MD) on 03/07/24 at 03:30 p.m., the four hot water heaters in mechanical rooms had permits that expired on 06/01/23. Based on interview at the time of the observation, the MD stated the inspection for the water heaters was completed but they have not received the permits. These findings were reviewed with the Executive Director and the MD at the exit conference. 3.1-19(b)	K 0500	**K500 – Building Services – Other** ***What corrective action will be accomplished for those residents found to have been affected by this deficient practice?*** 1 No significant negative outcomes to residents noted ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:*** 1 Other residents have the potential to be affected therefore the facility has secured current permits for all 4 fuel fired water heaters ensuring the water heaters are in safe operating condition. Please refer to attachments ***What measures and what systemic changes will be made to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place:*** 1 Maintenance Director and/or Administrator will inspect water	03/23/2024

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			heater certificates monthly times 2 months, every other month times 2 months, and quarterly thereafter to ensure certificates are current, and applying for renewal prior to February 2025 expiration dates. 2 The results of these reviews will be discussed at the monthly facility QAPI meeting each month for 3 months, then quarterly thereafter to ensure continued compliance. **Compliance Date: March 23, 2024. The Administrator at The Woodlands is responsible for ensuring compliance in this plan of correction.**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 20 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 6 residents. Findings include:	K 0511	**K511 – Utilities – Gas and Electric** ***What corrective Action will be accomplished for those residents found to have been affected by this deficient practice:*** 1 No significant negative outcomes to residents noted ***How other residents having the potential to be affected by the***	03/23/2024

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	Based on observation with the Maintenance Director (MD) on 03/07/24 at 03:15 p.m. when the electric receptacle located within 6 feet feet from the sink in the Activity Room was tested with a GFCI tester the electric receptacle did not trip. Based on interview at the time of observation, the MD agreed the GFCI electric receptacle within 6 feet of the sink in the Activity Room did not trip when tested. This finding was reviewed with the Executive Director and the MD during the exit conference. 3.1-19(b)		***same deficient practice will be identified and what corrective action will be taken:*** 1 Other residents have the potential to be affected therefore the 1 of 20 ground fault circuit interrupter (GFCI) outlet has been replaced. ***What measures and what systemic changes will be made to ensure that the deficient practice does not recur:*** 1 Maintenance Director will conduct GFCI outlet testing to ensure GFCI outlets are working properly ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:*** 1 Maintenance Director will conduct testing on GFCI outlets weekly times two months, bi-weekly times two months, and monthly times 2 months. 2 The results of these reviews will be discussed at the monthly facility QAPI meeting monthly for a total of 3 months, then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. Compliance Date: March 23, 2024. The Administrator at The Woodlands is responsible is ensuring compliance in this Plan of Correction	

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