STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 01 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND HILLS CARE CENTER	403 BIELBY ROAD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	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). Survey Date: 07/29/11 and 08/01/11 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Woodland Hills Care Center 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. This three story facility with a basement was determined to be of Type II (222) construction and fully sprinklered excluding the west second floor and third floor stairwells and the basement elevator equipment room. The facility has a fire alarm system with smoke detection in the	K0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending August 1, 2011. Should additional information be necessary to confirm said compliance, feel free to contact me.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 90 and had a census of 60 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/05/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of 25 basement rooms were provided with a corridor door capable of resisting the passage of smoke. This deficient practice affects any residents using the basement activity room and inside smoker's room.	K0018	**K018** requires the facility to provide smoke barriers with at least a 20-minute fire protection rating. The facility will ensure this requirement is met through the following corrective measures: 1. Residents were not affected or harmed 2. All residents have the potential to be affected. In the event residents need to be	08/31/2011

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	Findings include: Based on observation on 07/29/11 at 4:40 p.m. with the administrator and maintenance supervisor, the basement kitchen foyer, the basement kitchen dishwashing room, and basement kitchen elevator waiting room each lacked a door and were open to the corridor. This was verified by the administrator and maintenance supervisor at the time of observations. 3.1-19(b)		evacuated, necessary actions will be taken to evacuate by means other than the basement corridor. 3. The maintenance Supervisor was inserviced. Self-closing, Fire Rated doors will be installed in the basement kitchen foyer, the basement kitchen dishwashing room, and the basement kitchen elevator waiting room. Bids for this corrective measure will be obtained on or before August 31, 2011, supplies will be ordered and received on or before September 30, 2011, and the construction of the doors will be completed on or before September 30, 2011. 4. Audits will be conducted by the facility maintenance supervisor monthly to ensure other corridor doors are capable of resisting the passage of smoke. The audits will be reviewed during the facility' s quarterly quality assurance meetings. 5. The above corrective measures will be initiated and/or completed on or before August 31, 2011.	
K0027 SS=F	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 Based on observation and interview, the	K0027	**K027** requires the facility to provide smoke barriers at each	08/31/2011

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	facility failed to ensure 2 of 3 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 Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice affect 21 resident who reside on the second floor and 18 residents who reside on the third floor. Findings include: Based on observations on 08/01/11 during a tour of the facility from 10:30 a.m. to 2:30 p.m. with the administrator and maintenance supervisor, the second floor and third floor smoke barrier doors were tested twice and each smoke barrier door set coordinator did not allow the smoke barrier door sets to close when the non-astragal side of the smoke barrier doors were closed first. Each set of smoke barrier doors had a four inch gap where the coordinator prevented the doors from closing. This was verified by the administrator and maintenance supervisor at the time of observations. 3.1-19(b)		door openings with a 20-minute fire protection. The facility will ensure this requirement is met through the following corrective measures: 1. Residents were not affected or harmed. 2. All residents have the potential to be affected. The self-closing fire doors will be adjusted to ensure they close completely. 3. The maintenance supervisor was in serviced. The maintenance supervisor will utilize the Monthly Fire Drill Record form to audit the smoke barrier doors to ensure they correctly close when necessary. 4. The audits will be conducted monthly during each fire drill. The audits will also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures will be initiated or completed on or before August 31, 2011.	

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K0029 SS=E	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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 10 hazardous areas such as a soiled linen room was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 21 residents who reside on the second floor. Findings include: Based on observations on 08/01/11 at 1:45 p.m. with the administrator and maintenance supervisor, the second floor soiled linen room door self closing device failed to close and latch the door into the door frame and left a one inch gap along the latching side of the door. This was verified by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)	K0029	**K029** requires the facility to ensure doors leading to a corridor are provided with a self-closing device which would cause the door to automatically close and latch into the door frame. . The facility will ensure this requirement is met through the following corrective measures: 1. Residents were not affected or harmed. 2. All residents have the potential to be affected. . All doors which are self-closing or automatic closing will be audited to ensure they are in compliance with 19.2.2.2.6. . The self-closing device attached to the second floor soiled utility room will be replaced with a new self-closing device to ensure the door closes and latches into the door frame. 3. The maintenance supervisor was in serviced. The maintenance supervisor will monitor the second floor soiled utility room door weekly for one month, then quarterly thereafter. 4. All self-closing doors will be tested monthly to ensure they latch into	08/31/2011

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			the door frame. The audits will also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures will be initiated or completed on or before August 31, 2011.	
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 3 of 3 battery backup lights were tested monthly over the past year to ensure the lights would provide lighting during periods of power outages to protect 60 of 60 residents. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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 affect any residents and staff in the first floor therapy room. Findings include:	K0046	K046 requires the facility to ensure battery backup lights are functionally tested at 30 day intervals for not less than 30 second s and annually tested for not less than 90 minutes. The facility will ensure this requirement is met through the following corrective measures. 1. . Residents were not affected or harmed. 2. All residents have the potential to be affected. All battery backup lights will be tested monthly for at least 30 seconds and annually for at least 90 minutes. 3. The maintenance supervisor was inserviced. A battery was replaced in one of the three backup lights. The lights were tested and operational. 4. The maintenance supervisor will monitor and audit the battery backup lights at 30 day intervals and annually. The audits will also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures will be initiated or completed on or before August 31, 2011.	08/31/2011

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	Based on observation on 08/01/11 at 2:10 p.m. with the administrator and maintenance supervisor, the first floor therapy room had three battery backup lights mounted on the walls illuminating the exit signs and provided with double light fixtures. Based on an interview with the maintenance supervisor on 08/01/11 at 2:15 p.m., the three therapy room battery powered backup lights are not tested monthly or tested annually for a ninety minute duration. This was verified by the administrator at the time of interview. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were held on 2 of 3 shifts over the past year and ensure 1 of the past 10 fire drills conducted over the past year had a time listed on the fire drill report. This deficient practice affects all resident in the	K0050	**K050** requires the facility to plan and conduct fire drills at unexpected times under carrying conditions, at least quarterly on each shift. The facility will ensure this requirement is met through the following corrective measures. 1. Residents were not affected of harmed. 2. All	08/31/2011

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	facility. Findings include: Based on review of the 2011 Monthly Fire Drill Record with the administrator and maintenance supervisor on 07/29/11 at 11:50 a.m., there was no record of a fire drill conducted on first shift for the first quarter of the year 2011, and a third shift fire drill for the second quarter of the year 2011. Furthermore, the previous first shift fire drill before the first quarter of 2011 was conducted on 12/31/10 at 12:55 p.m., the first shift fire drill for the second quarter 2011 was conducted on 06/17/11 at 1:00 p.m., and the previous third shift fire drill before the second quarter 2011 was conducted on 03/20/11 with no time listed on the fire drill report and the previous drill with a time listed on third shift was conducted on 10/13/10 at 5:20 a.m. Both missed fire drills had a period exceeding the three month requirement. The lack of a fire drill record for first shift first quarter for the year 2011 and second quarter third shift for the year 2011 was verified by the administrator and maintenance supervisor at the time of record review. 3.1-19(b)		residents have the potential to be affected. Monthly fire drills will be conducted as scheduled and quarterly on each shift. 3. The maintenance supervisor has been inserviced regarding the fire drill procedures. The Fire Drills will be conducted by the maintenance supervisor and monitored by the administrator. 4. A Monthly Fire Drill Record form is being utilized for each monthly fire drill. The audits will also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures will be initiated or completed on or before August 31, 2011.	

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K0056 SS=E	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 Based on observation and interview, the facility failed to ensure 1 of 25 basement rooms were completely sprinklered. This deficient practice could affect any resident who use the basement activity room and basement inside smokers room. Findings include: Based on observation on 07/29/11 at 4:05 p.m. with the administrator and maintenance supervisor, the basement elevator equipment room was not provided with complete sprinkler coverage. The room consisted of a twelve foot by fourteen foot room with a ten foot recessed alcove along the basement wall with sprinkler coverage in the enclosed alcove. Furthermore, the elevator equipment room had one elevator oil filled machine housed in a metal enclosure and the other operational	K0056	K056 requires the facility to be equipped with an automatic sprinkler system to provide complete coverage for all portions of the building. The facility will ensure this requirement is met through the following corrective measures. 1. Residents were not affected of harmed. 2. All residents have the potential to be affected. The basement elevator equipment room will be completely sprinklered. 3. The Administrator and maintenance supervisor were inserviced. Bids for this corrective measure will be obtained on or before August 31, 2011, supplies will be ordered and received on or before September 30, 2011, and the sprinklers will be installed on or before September 30, 2011. 4. Audits will be conducted by the facility maintenance supervisor monthly for six months to ensure areas in the facility are sprinklered. The audits will be reviewed during the facility's quarterly quality	08/31/2011

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	equipment for the elevator was located in the mechanical room across the corridor from the elevator equipment room. The elevator room was enclosed with concrete block construction, and a twenty minute fire rated self closing door. This was verified by the administrator and maintenance supervisor at the time of observation. 3.1-19(b)		assurance meetings. 5. The above corrective measures will be initiated and/or completed on or before August 31, 2011.	
K0130 SS=F	OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 1 of 1 boilers and 1 of 1 water heaters had an inspection certificate which were current to ensure the equipment was in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents in the facility. Findings include: Based on review of the American model hot water heater and Peerless model boiler inspection certificates with the administrator and maintenance supervisor on 07/29/11 at 11:50 a.m., the inspection certificates had an expiration date of	K0130	**K130** requires the facility to obtain inspection certificates on water heater boilers. The facility will ensure this requirement is met through the following corrective measures. 1. Residents were not affected of harmed. 2. All residents have the potential to be affected. All boilers in the facility will be inspected and certified annually. 3. The maintenance supervisor was inserviced. The maintenance supervisor will monitor and audit the boilers monthly to ensure each has a current certificate. The audits will also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures will be completed on or before August 21, 2011.	08/31/2011

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	07/11/11. Based on an interview with the administrator and maintenance supervisor on 07/29/11 at 11:55 a.m., it was stated there are no current two year inspection certificates for the American model hot water heater and Peerless model boiler. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure the load testing for the past 12 months was conducted under operating conditions or not less than 30 percent of the nameplate rating for the emergency generator set to protect 60 of 60 residents. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance,	K0144	K144 requires the facility to inspect the generator weekly and under load for 30 minutes monthly. The facility will ensure this requirement is met through the following corrective measures. 1. Residents were not affected of harmed. 2. All residents have the potential to be affected. Weekly generator checks and monthly load tests will be documented by the maintenance supervisor. 3. The maintenance supervisor will be inserviced. The maintenance supervisor will utilize the Generator Testing Log Book weekly to monitor the generator and monthly to document the load test for 30 minutes. The audits will also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures will be completed on or before August	08/31/2011

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	exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affect all residents in the facility. Findings include: Based on a review of the Generator Testing Log Book on 07/29/11 at 1:30 p.m. with the administrator and maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes but did not indicate a thirty percent rated test was conducted during each load test. Based on an interview with the maintenance supervisor on 07/29/11 at 1:40 p.m., the monthly load tests ran by a timer for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. This was verified by the maintenance supervisor at the time of observation and interview. 3.1-19(b)		31, 2011.	
K9999	Sttatte Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(fl) A healtth flacilitty licensed under IC 16-28 as a comprehensive care flacilitty mustt do tthe flollowing (1) Have an auttomattc flre sprinkler	K9999	**K999** requires the facility to have an automatic sprinkler system installed throughout the facility before July 1, 2012. The facility will ensure this requirement is met through the following corrective measures. 1. Residents were not affected of harmed. 2. All residents have the potential to be affected. The stairwells on the West side will	08/31/2011

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WOODLAND HILLS CARE CENTER	403 BIELBY ROAD LAWRENCEBURG, IN47025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	systtem insttalled tthroughoutt tthe flacilitty beflore July1, 2012. (2) Ifl an auttomattc flre sprinkler systtem is nott insttalled tthroughoutt tthe healttth flacilitty beflore July1, 2010 submitt beflore July1, 2010, a plan tto tthe sttatte departtmentt flor complettng tthe insttallatton ofl tthe auttomattc sprinkler systtem beflore July1, 2012. (3) Have a battery operatted or hard wired smoke dettecttor in each residentt' s room beflore July1, 2012. This Sttatte Rule is nott mett as evidenced by: Based on observatton and intterview, tthe flacilitty flailed tto ensure tthe enttre flacilitty was sprinklered. This deflcientt practtce could aflectt all residentts, sttafl and visittors. Findings include: Based on observattons during a ttour ofl tthe flacilitty flrom 10:30 a.m. tto 2:45 p.m. on 08/01/11 witth tthe administtrattor and mainttenance supervisor, tthe second floor and tthird floor sttairwells on tthe westt side ofl tthe flacilitty were nott sprinklered. The lack ofl sprinkler coverage was acknowledged by tthe administtrattor and mainttenance supervisor att tthe ttme ofl observattons 3.1-19(ff)		have sprinklers installed. 3. The Administrator and maintenance supervisor were inserviced. Bids for this corrective measure will be obtained on or before August 31, 2011, supplies will be ordered and received on or before September 30, 2011, and the sprinklers will be installed on or before Septemberr 30, 2011. 4. Audits will be conducted by the facility maintenance supervisor monthly for six months to ensure areas in the facility are sprinklered. The audits will be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures will be initiated and/or completed on or before August 31, 2011.	