PRINTED: FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155061 08/01/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **403 BIELBY ROAD** WOODLAND HILLS CARE CENTER LAWRENCEBURG, IN47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE K0000 Submission of this plan of K0000 A Life Safety Code Recertification and correction does not constitute State Licensure Survey was conducted by admission or agreement by the the Indiana State Department of Health in provider of the truth of facts accordance with 42 CFR 483.70(a). alleged or correction set forth on the statement of deficiencies. This plan of correction is Survey Date: 07/29/11 and 08/01/11 prepared and submitted because of requirement under state and Facility Number: 000022 federal law. Please accept this Provider Number: 155061 plan of correction as our credible allegation of compliance. Please AIM Number: 100274510 find enclosed the plan of correction for the survey ending Surveyor: Mark Bugni, Life Safety Code August 1, 2011. Should additional information be Specialist necessary to confirm said compliance, feel free to contact 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5FOV21

Facility ID:

000022

If continuation sheet

08/23/2011

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155061	B. WING		08/01/2011
NAME OF P	ROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE	
WOODLA	AND HILLS CARE O	CENTER		ELBY ROAD ENCEBURG, IN47025	
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	ID	, 	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	corridors, spaces	open to the corridors,			
	and all resident s	leeping rooms. The			
	facility has a cap	acity of 90 and had a			
	census of 60 at the	ne time of this visit.			
	Quality Review by I	Robert Booher, Life Safety			
		dical Surveyor on 08/05/11.			
	The facility was	found not in compliance			
	_	ntioned regulatory			
	requirements as	c ,			
	following:	evidenced by the			
	Tone wing.				
K0018 SS=E	than required enclexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with a keeping the door of meeting 19.3.6.3.6.	prohibited by CMS			
	Based on observation facility failed to crooms were provergable of resistion. This deficient pro-	ne basement activity	K0018	K018 requires the facility to provide smoke barriers with a least a 20-minute fire protect rating. The facility will ensure requirement is met through the following corrective measure Residents were not affected harmed 2. All residents have potential to be affected. In the event residents need to be	ion e this ne s: 1. or e the

ANDILANC	OF CORRECTION	IDENTIFICATION NUMBER: 155061	A. BUILDING	01	COMPLET	ILD
		155061			08/01/20 <sup>2</sup>	
NAME OF PROMIDER OF GUIDNIER			B. WING	ADDRESS OWN COURT ON SORE	00/01/20	
NAME OF PR	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	ND HILLS CARE C	CENTER		ELBY ROAD ENCEBURG, IN47025		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
K0027 SS=F	Based on observations, with the adriantenance superitive dishwashing roomelevator waiting and were open to This was verified maintenance superitive dishwashing roomelevator waiting and were open to This was verified maintenance superitive dishwashing roomelevator waiting and were open to This was verified maintenance superitive dishwashing roomelevations.  3.1-19(b)  Door openings in a a 20-minute fire prieast 13/4-inch thick Non-rated protective 48 inches from the permitted. Horizon with 7.2.1.14. Door automatic closing 19.2.2.2.6. Swing	ation on 07/29/11 at 4:40 ministrator and ervisor, the basement e basement kitchen m, and basement kitchen room each lacked a door the corridor. I by the administrator and ervisor at the time of  smoke barriers have at least otection rating or are at a solid bonded wood core. We plates that do not exceed bottom of the door are ntal sliding doors comply ors are self-closing or in accordance with ing doors are not required	TAG	evacuated, necessary action be taken to evacuate by mea other than the basement corridor. 3. The maintenance Supervisor was inserviced. Self-closing, Fire Rated door be installed in the basement kitchen foyer, the basement kitchen dishwashing room, at the basement kitchen elevated waiting room. Bids for this corrective measure will be obtained on or before August 2011, supplies will be ordere received on or before Septer 30, 2011, and the construction the doors will be completed to before September 30, 2011. Audits will be conducted by facility maintenance supervision monthly to ensure other corridoors are capable of resisting passage of smoke. The aud will be reviewed during the fast quarterly quality assurance meetings. 5. The above corrective measures will be initiated and/or completed or before August 31, 2011.	s will  nd or  st 31, d and ober on of on or 4. the or dor g the its acility'	DATE
		ss and positive latching is				
		.3.7.5, 19.3.7.6, 19.3.7.7 ation and interview, the	K0027	K027 requires the facility to provide smoke barriers at ea		08/31/2011

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU COMPLET	
AND PLAN	OF CORRECTION	155061	A. BUI	LDING	01	08/01/201	
		133001	B. WIN		PRESIDENCE CONTROL CON	00/01/201	11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	AND HILLS CARE C	CENTER			NCEBURG, IN47025		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re (	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	door openings with a 20-min	uto	DATE
ı		ensure 2 of 3 sets of ors would restrict the			fire protection. The facility w		
		oke for at least 20			ensure this requirement is m	et	
					through the following correcti		
		9.3.7.6 requires doors in			measures: 1. Residents wer affected or harmed. 2. All	e not	
		nall comply with Section .1 requires doors in			residents have the potential t	to be	
		*			affected. The self-closing fire	.	
		nall close the opening			doors will be adjusted to ens		
		minimum clearance oper operation which is			they close completely. 3. T maintenance supervisor was		
		ch. This deficient			serviced. The maintenance	"'	
		resident who reside on			supervisor will utilize the Mor	nthly	
	*	and 18 residents who			Fire Drill Record form to audi		
	reside on the thir				smoke barrier doors to ensur they correctly close when	e	
	reside on the thir	d 11001.			necessary. 4. The audits wi	ll be	
	Findings include	:			conducted monthly during ea fire drill. The audits will also	ıch	
	Based on observa a tour of the facil 2:30 p.m. with the maintenance super and third floor set tested twice and of set coordinator de barrier door sets non-astragal side doors were closed smoke barrier do where the coordination. The	ations on 08/01/11 during lity from 10:30 a.m. to the administrator and the ervisor, the second floor moke barrier doors were the each smoke barrier door id not allow the smoke to close when the to fthe smoke barrier d first. Each set of the ors had a four inch gap mator prevented the doors this was verified by the d maintenance supervisor			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.		
	3.1-19(b)						

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  ensure doors leading to a corridor are provided with a self-closing device which would cause the door to automatically close and latch 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 frame. 3. The	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER  WOODLAND HILLS CARE CENTER  WOODLAND HILLS CARE CENTER  LAWRENCEBURG, IN47025  LAWRE	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	DING	01	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER  WOODLAND HILLS CARE CENTER  (X4) ID PRETRY (24) CHART STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL TAG (25) CHART STATE (26) CHART STATE (26			155061				08/01/2	011
REFIX (BACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SS=E  On hour fire rated construction (with % 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	WOODL	AND HILLS CARE C	CENTER		403 BIE LAWRE	ELBY ROAD		
REGULATORY OR LSC IDENTIFYING INFORMATION)  SS=E  One hour fire rated construction (with ½ 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						PROVIDER'S PLAN OF CORRECTION		
SS=E    Comparison of the Comparison of the Comparison of the Score of the Comparison of the Compariso		`				CROSS-REFERENCED TO THE APPROPRIAT	ΓE	
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				+	TAG	DEFICIENCY)		DATE
the latching side of the door.  This was verified by the administrator and maintenance supervisor at the time of observation.  This was verified by the administrator and maintenance supervisor at the time of observation.  This was verified by the administrator and 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		fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1  Based on observations facility failed to do to 1 of 10 hazard linen room was pelosing device with door to automation the door frame. Could affect 21 rethe second floor.  Findings include  Based on observation p.m. with the administration of the latching side the latching side This was verified maintenance supposervation.	r an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. Ed automatic fire em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied hat do not exceed 48 inches if the door are permitted.  ation and interview, the ensure the corridor door dous areas such as a soiled provided with a self hich would cause the cally close and latch into This deficient practice esidents who reside on  :  ations on 08/01/11 at 1:45 ministrator and ervisor, the second floor in door self closing device and latch the door into the eft a one inch gap along of the door. If by the administrator and	K	0029	ensure doors leading to a co are provided with a self-closi device which would cause th door to automatically close a latch into the door frame. facility will ensure this requirement is met through the following corrective measure Residents were not affected harmed. 2. All residents have the potential to be affected. In doors which are self-closing automatic closing will be aud to ensure they are in complia with 19.2.2.2.6. The self-closing device attached second floor soiled utility roo be replaced with a new self-closing device to ensure door closes and latches into door frame. 3. The maintenance supervisor was serviced. The maintenance supervisor was serviced utility room door weekly for one month, then quarterly thereafter. 4. All self-closing doors will be test	ng e nd The ne s: 1. or /e All or ited ance to the m will the the in	08/31/2011

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/23/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPLETED 08/01/2011	
		155061	B. WIN			06/01/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WOODLA	AND HILLS CARE C	ENTER			elby road Enceburg, in47025		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0046 SS=E	duration is provide 19.2.9.1.  Based on observate facility failed to estable backup lights were the past year to exprovide lighting outages to protect LSC 19.2.9.1 required shall be provided Section 7.9. Sect functional test she every required enat 30 day interval seconds. An annuconducted on every powered emerger not less than 1 1/2 shall be fully ope of the test. Writtinspections and to owner for inspect having jurisdictions.	ery required battery ney lighting system for 2 hours. Equipment erational for the duration en records of visual ests shall be kept by the tion by the authority on. This deficient y residents and staff in rapy room.	KO	0046	the door frame. The audits walso be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures winitiated or completed on or before August 31, 2011.  K046 requires the facility to ensure battery backup lights functionally tested at 30 day intervals for not less than 30 second s and annually tested not less than 90 minutes. The facility will ensure this requirement is met through the following corrective measures 1. Residents were not affect or harmed. 2. All residents with the potential to be affected. It battery backup lights will be tested monthly for at least 30 seconds and annually for at 1 90 minutes. 3. The maintenas supervisor was inserviced. A battery was replaced in one of three backup lights. The ligh were tested and operational. The maintenance supervisor monitor and audit the battery backup lights at 30 day intervand annually. The audits will be reviewed during the facility quarterly quality assurance meetings. 5. The above corrective measures will be initiated or completed on or before August 31, 2011.	are I for e e s. cted have All east ance of the ts 4. will vals	08/31/2011
	i mampo merade.	•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5FOV21 Facility ID:

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	(X2) MUL' A. BUILD! B. WING		01	(X3) DATE S COMPL 08/01/20	ETED
	PROVIDER OR SUPPLIER		4	403 BIEL	DDRESS, CITY, STATE, ZIP CODE LBY ROAD NCEBURG, IN47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K0050 SS=F	p.m. with the adrimaintenance suptherapy room had lights mounted of the exit signs and light fixtures. But the maintenance 2:15 p.m., the throwever backup monthly or tested minute duration. This was verified the time of intervals.  3.1-19(b)  Fire drills are held varying conditions shift. The staff is fis aware that drills routine. Responsi conducting drills is competent person exercise leadershic conducted between announcement manudible alarms.  Based on record facility failed to on held on 2 of 3 shiensure 1 of the paconducted over the listed on the fire	ervisor, the first floor If three battery backup In the walls illuminating If provided with double If the seed on an interview with If supervisor on 08/01/11 at If the etherapy room battery It lights are not tested If annually for a ninety If by the administrator at If the extreme with supervisor on tested If annually for a ninety If the administrator at the extreme with the procedures and are part of established bility for planning and the assigned only to so who are qualified to p. Where drills are If the pervisor of the past year and the past year had a time with procedure with the past year had a time with the past year had a time with provided the provide	K00	50	K050 requires the facility to pand conduct fire drills at unexpected times under carry conditions, at least quarterly each shift. The facility will enthis requirement is met through the following corrective measures. 1. Residents we not affected of harmed. 2. A	ying on isure gh	08/31/2011

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Event ID: 5FOV21 Facility ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155061			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED - 08/01/2011		
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CE	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  403 BIELBY ROAD  LAWRENCEBURG, IN47025					
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PERCEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
facility.  Findings include:  Based on review of Drill Record with maintenance super 11:50 a.m., there will conducted on quarter of the year fire drill for the seconducted on the first shift fire drill before the was conducted on the first shift fire drill before the was conducted on the fire drill before the was conducted on listed on the fire drill before the was conducted on listed on the fire drill with shift was conducted a.m. Both missed exceeding the three The lack of a fire of first quarter for the quarter third shift is verified by the admits the same provise of the same	of the 2011 Monthly Fire the administrator and rvisor on 07/29/11 at was no record of a fire first shift for the first 2011, and a third shift cond quarter of the year e, the previous first shift e first quarter of 2011 12/31/10 at 12:55 p.m., drill for the second conducted on 06/17/11 he previous third shift e second quarter 2011 03/20/11 with no time rill report and the a time listed on third ed on 10/13/10 at 5:20 fire drills had a period the month requirement. drill record for first shift e year 2011 and second for the year 2011 was			residents have the potential taffected. Monthly fire drills we conducted as scheduled and quarterly on each shift. 3. The maintenance supervisor has inserviced regarding the fire procedures. The Fire Drills were conducted by the maintensupervisor and monitored by administrator. 4. A Monthly Drill Record form is being utilifor each monthly fire drill. The audits will also be reviewed during the facility's quarterly quality assurance meetings. The above corrective measur will be initiated or completed or before August 31, 2011.	vill be he been drill vill sance the Fire sized ne		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUIDENTIFICATION NUMBER:  155061 A. BUILDING B. WING B. WING		ETED					
	PROVIDER OR SUPPLIER		·	403 BIE	DDRESS, CITY, STATE, ZIP CODE LBY ROAD NCEBURG, IN47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0056 SS=E	installed in accord Standard for the Ir Systems, to provice portions of the buil properly maintaine 25, Standard for th Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat switches, which ar the building fire als Based on observa facility failed to rooms were come deficient practice who use the base basement inside  Findings include  Based on observa p.m. with the admaintenance sup elevator equipment provided with co coverage. The re foot by fourteen recessed alcove a with sprinkler co alcove. Furthern equipment room filled machine he	ation and interview, the ensure 1 of 25 basement pletely sprinklered. This e could affect any resident ement activity room and smokers room.  :  ation on 07/29/11 at 4:05 ministrator and ervisor, the basement ent room was not emplete sprinkler boom consisted of a twelve foot room with a ten foot along the basement wall overage in the enclosed more, the elevator had one elevator oil	K0	056	K056 requires the facility to be equipped with an automatic sprinkler system to provide complete coverage for all poof the building. The facility wensure this requirement is measures. 1. Residents we not affected of harmed. 2. A residents have the potential affected. The basement elevequipment room will be completely sprinklered. 3. The Administrator and maintenar supervisor were inserviced. For this corrective measure we obtained on or before Augus 2011, supplies will be ordere received on or before Septem 30, 2011, and the sprinklers be installed on or before September 30, 2011. 4. Auguill be conducted by the facility are sprinklered. The audits will be reviewed during facility's quarterly quality	rtions rill et ive re All to be rator The ace Bids rill be t 31, d and mber will dits litty athly as in	08/31/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5FOV21 Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:				JLTIPLE CO	NSTRUCTION 01	(X3) DATE S COMPL	
ANDIEM	or connection	155061	A. BUII B. WIN		01	08/01/2	
			D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			403 BIE	LBY ROAD		
WOODL	AND HILLS CARE C	CENTER		LAWRE	NCEBURG, IN47025		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	COMPLETION DATE
K0130 SS=F	equipment for the the mechanical refrom the elevator from was block construction fire rated self clowerified by the admaintenance supposservation.  3.1-19(b)  OTHER LSC DEF  Based on record facility failed to a lof 1 water heat certificate which the equipment was condition. NFPA all health facilities operated to mininfire emergency reoccupants. This affect all residents  Findings include  Based on review hot water heater inspection certificate and inspection certificate inspection certificate administrator and	ICIENCY NOT ON 2786  review and interview, the ensure 1 of 1 boilers and ers had an inspection were current to ensure as in safe operating 101 in 19.1.1.3 requires es to be maintained and mize the possibility of a equiring the evacuation of deficient practice could ts in the facility.  of the American model and Peerless model boiler	K	TAG	assurance meetings. 5. The above corrective measures vinitiated and/or completed or before August 31, 2011.  K130 requires the facility to obtain inspection certificates water heater boilers. The facility meet through the following corrective measures. 1. Residents were not affected harmed. 2. All residents have the potential to be affected. boilers in the facility will be inspected and certified annuals. The maintenance supervives inserviced. The maintenance supervives monthly to ensure each has current certificate. The audit also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures we completed on or before August 21, 2011.	on cility is of ve All ally. sor	DATE  08/31/2011
	Findings include  Based on review hot water heater inspection certifical administrator and on 07/29/11 at 11	of the American model and Peerless model boiler cates with the dimaintenance supervisor			maintenance supervisor will monitor and audit the boilers monthly to ensure each has current certificate. The audit also be reviewed during the facility's quarterly quality assurance meetings. 5. The above corrective measures v completed on or before Augu	a s will e vill be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155061			A. BUILI	DING	O1	(X3) DATE S COMPL 08/01/2	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET AD	DDRESS, CITY, STATE, ZIP CODE  BY ROAD  NCEBURG, IN47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
K0144 SS=F	o7/11/11. Based administrator and on 07/29/11 at 11 there are no curre certificates for the water heater and 3.1-19(b)  Generators are insexercised under low month in accordar 3.4.4.1.  Based on record facility failed to the past 12 month operating conditing percent of the nate emergency generator serving system to be in a 110, the Standard Standby Powers	on an interview with the dimaintenance supervisor 1:55 a.m., it was stated ent two year inspection e American model hot Peerless model boiler.  Spected weekly and had for 30 minutes per nice with NFPA 99.  The review and interview, the ensure the load testing for the was conducted under ons or not less than 30 meplate rating for the rator set to protect 60 of apter 3-4.4.1.1 of NFPA	K0		K144 requires the facility to inspect the generator weekly under load for 30 minutes monthly. The facility will ens this requirement is met through the following corrective measures. 1. Residents we not affected of harmed. 2. A residents have the potential taffected. Weekly generator checks and monthly load test be documented by the maintenance supervisor. 3. maintenance supervisor will be inserviced. The maintenance supervisor will be inserviced. The maintenance supervisor will utilize the	and ure gh re tll o be ts will The	DATE  08/31/2011
	service to be execonditions or not the EPS namepla for a minimum o 3-5.4.2 of NFPA	Level 1 and Level 2 reised under operating less than 30 percent of te rating at least monthly, f 30 minutes. Chapter 99 requires a written ion, performance,			Generator Testing Log Book weekly to monitor the genera and monthly to document the test for 30 minutes. The aud will also be reviewed during t facility's quarterly quality assurance meetings. 5. The above corrective measures we completed on or before Augurents.	load its he vill be	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155061	B. WING			08/01/2	011
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				LBY ROAD		
	AND HILLS CARE (	CENTER	LAWRENCEBURG, IN47025				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		l, and repairs for the			31, 2011.		
	_	egularly maintained and					
	available for insp	pection by the authority					
	having jurisdiction	on. This deficient					
	practice affect al	l residents in the facility.					
	•	-					
	Findings include	:					
	Book on 07/29/11 at administrator and m Generator Testing L load test for each of thirty minutes but dirated test was condu Based on an intervies supervisor on 07/29 load tests ran by a tilduration and there a operating temperatur running on a thirty riverified by the main of observation and in	aintenance supervisor, the og Book showed a monthly the past twelve months for id not indicate a thirty percent acted during each load test. we with the maintenance /11 at 1:40 p.m., the monthly mer for a thirty minute re no gauges to monitor res while the generator is minute load test. This was attenance supervisor at the time					
K9999	3.1-19(b)						
13///7							
	Sttatte Findings		K9	999	<b>K999</b> requires the facility to an automatic sprinkler system		08/31/2011
	2.4.40 ENU (IDON) :-	ALT AND DUVCICAL			installed throughout the facili	, ,	
	3.1-19 ENVIRONME	NT AND PHYSICAL			before July 1, 2012. The facil		
	STANDARDS				will ensure this requirement is met through the following	s	
	3.1-19(fl) A healtth	flacilitty licensed under IC			corrective measures. 1.		
	16-28 as a compreh	ensive care flacilitty mustt			Residents were not affected	of	
	do tthe flollowing				harmed. 2. All residents have		
	9	ttomattc fire sprinkler			the potential to be affected. stairwells on the West side w		

000022

NAME OF PROVIDER OR SUPPLIER  WOODLAND HILLS CARE CENTER  WOODLAND HILLS CARE CENTER  LAWRENCEBURG, IN47025  SYSTEM INSTALLEMENT OF DEFICIENCES  System installed throughout the flacility beflore Julyl, 2012.  (2) If an auttomatte fire sprinkler system is not installed throughout the health flacility beflore Julyl, 2010, a plan to the statte department fro completing the installation off the auttomatte sprinkler system beflore Julyl, 2012.  (3) Have a battery operatted or hard wired smoke dettecttor in each resident's room beflore Julyl, 2012.  This State Rule is nott mett as evidenced by Based on observation and interview the flacility flailed to ensure the entire flacility was sprinklered. This deficient practice could affect all resident; staff and visitors  Findings include:  Based on observations during a tour off the flacility florago 30 a.m. tto2:45 p.m. on 08/01/11 with the administrator and mainttenance supervisor the vest side off the flacility were nott sprinklers for law and mainttenance supervisor the second floor and third floor statinvells on the west side off the flacility were nott sprinklers find long and third floor statinvells on the west side off the flacility were nott sprinklers find long and third floor statinvells on the west side off the flacility were nott sprinklers find long and third floor statinvells on the west side off the flacility were nott sprinklers find lack off		MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	ONSTRUCTION 01	l .	(3) DATE SURVEY  COMPLETED	
NAME OF PROVIDER OR SUPPLIER  WOODLAND HILLS CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFEX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG SEGULATORY OF ICS IDENTIFYING INFORMATION)  systlem installed throughout the flacility beflore July1, 2012.  (2) Iff an auttomatic fire sprinkler system is not installed throughout the heating the installed of the systlem of the state department flor completing the installation of it the auttomatic sprinkler systlem beflore July1, 2012.  (3) Have a battery operatted or hard wired smoke dettector in each resident's room beflore July1, 2012.  This State Rule is not mett as evidencedby Based on observation and interview the flacility flailed the ensure the entire flacility was sprinklered. This deficient practice could affect all residentististation on BAC 11.  Based on observations during a tour off the flacility were not sprinklered he lack off the flacility were not sprinklered he lack off	ANDIEAN	or conduction		- 1		01			
WOODLAND HILLS CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPCIENCY MUST BE PERCEDED BY FULL REGULATORY OR LIKE (DENTIFYING INFORMATION)  Systtem installed throughout the flacility beflore Julyl, 2012.  (2) Iff an auttomatic fire sprinkler system is not installed throughout the health flacility beflore Julyl, 2010, a plan to the stated department flor completing the installation off the auttomatic sprinkler system beflore Julyl, 2012.  (3) Have a battery operatted or hard wired smoke detection in each resident's room beflore Julyl, 2012.  This State Rule is not met as evidenced by Based on observation and interview the flacility flailed tto ensure the entire flacility was sprinklered. This deficient practice could affect all residentitystiff and visitions  Findings include:  403 BIELBY ROAD LAWRENCEBURG, IN47025  (X5)  PREFIX TAG  ID PROVIDER OR IN47025  ID DEVINITION ORDITION (IX5)  ID DEVINITION OF CORRECTION (IX5)  (X5)  COMPLETION DATE  Administrator and maintenance supervisor time seasure will be obtained on or before August 31, 2011, supplies will be conducted by the facility was in the facility as prinklered. The audits will be reviewed during the facility signal propriet on or before August 31, 2011.  This State Rule is not met as evidenced by Based on observation and interview the flacility flailed to ensure the entire flacility was sprinklered. This deficient practice could affect all residentitystiff and visitions  Findings include:  Based on observations during a tour off tithe flacility florinto-30 a.m. tto2-45 p.m. on 08/01/11 with the administrator and maintenance supervisor title second floor and third floor stairwells on the west side off the flacility were not sprinklered he lack off				B. WIN		ADDRESS CITY STATE ZIP CODE			
ID   REFERN   GEACH DEFICIENCY MUST BE PERCEDED BY FULL   PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   Regulatory or LSC IDENTIFYING INFORMATION   TAG   TAG   Regulatory or LSC IDENTIFYING INFORMATION   TAG	NAME OF P	PROVIDER OR SUPPLIEF	R						
PREFIX TAG REGILATORY OR ISC IDENTIFYING INFORMATION)  system installed throughout the flacility beflore July1, 2012.  (2) Ifl an auttomattc fire sprinkler system is not installed throughout the health flacility beflore July1, 2010, a plan tto the state department flor completing the installation off the auttomattc sprinkler system beflore July1, 2012.  (3) Have a battery operated or hard wired smoke dettector in each resident's room beflore July1, 2012.  This Statite Rule is not met as evidenced by Based on observation and interview the flacility flailed to ensure the entire flacility was sprinklered. This deficient practice could affect all residentsystafi and visitors  Pindings include:  Based on observations during a tour off the facility with the administrator and maintenance supervisor were inserviced. Bids for this corrective measure will be obtained an arceived maintenance supervisor were inserviced. Bids for this corrective measure will be obtained an appearance on pefore supervisor were inserviced. Bids for this corrective measure will be obtained and received measure will be obtained 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 grained and or observed during the facility flained on or before August 31, 2011.	WOODLA	AND HILLS CARE (	CENTER		LAWRE	ENCEBURG, IN47025			
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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 assurance meetings. 5. The above corrective measures will be initiated and/or completed on or before August 31, 2011.  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 assurance meetings. 5. The above corrective measures will be initiated and/or completed on or before August 31, 2011.  Based on observattons during a ttour off the facility firom0:30 a.m. tto2:45 p.m. on 08/01/11 witth the administrattor and maintenance supervisor the second floor and tthird floor strairwells on the westt side off the facility were nott sprinklered he lack off						be installed on or before			
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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 the flacility flailed to ensure the enttre flacility was sprinklered. This deflicient practice could affectt all residenttssttafl and visittors  Findings include:  Based on observattons during a ttour off the flacility floral0:30 a.m. tto2:45 p.m. on 08/01/11 witth the administrattor and mainttenance supervisor the second floor and tthird floor sttairwells on the westt side off tthe flacility were nott sprinklered he lack off		(3) Have a battery operatted or hard							
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tthe flacilitty were nott sprinkleređhe lack ofl		mainttenance supe	rvisor tthe second floor						
		and tthird floor stta	irwells on tthe westt side ofl						
corinkler coverage was asknowledged by the		tthe flacilitty were r	nott sprinkleređhe lack ofl						
sprinkler coverage was acknowledged by tthe		sprinkler coverage v	was acknowledged by tthe						
administtrattor and mainttenance supervisor att		administtrattor and	mainttenance supervisor att						
tthe ttme ofl observattons		tthe ttme ofl observ	vattons						
3.1-19(ff)		3.1-19(ff)							