STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155086	A. BUILDING -- B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

(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: 06/11/24 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this Emergency Preparedness survey, Woodland Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 certified beds. At the time of the survey, the census was 67. Quality Review completed on 06/18/24	E 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 4th, 2024 to the life safety survey completed on June 11th, 2024. We respectfully request a paper review and will provide any additional information requested.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Wright	Administrator	07/04/2024

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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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice			

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	employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants.	E 0018	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to have been affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be***	07/04/2024

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	Findings include: Based on record review with the Administrator on 06/11/24 at 12:10 p.m., no policies and procedures that include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on record review the policy stated the Administrator is responsible for tracking residents but no policy, procedure or tracking log was available. Based on interview at the time of record review, the Administrator stated "no actual log" for tracking was available. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.		***identified and what corrective action(s) will be taken:*** All residents and staff have the potential to be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** The Administrator/Designee has created a tracking log to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The Administrator/Designee will review the tracking log and any negative findings will be immediately remedied. The results of the review will be addressed by the Quality Assurance Process Improvement committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** July 4th, 2024	
E 0032 SS=F Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3)			

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	Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Administrator	E 0032	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to have been affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:***	07/04/2024

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	on 06/11/24 at 12:24 p.m., the emergency preparedness plan did not address primary and alternate means for communication. Based on interview at the time of records review, the Administrator was not able to provide documentation or explain a primary and alternate means of communication. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference.		All residents and staff have the potential to be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** The Administrator/Designee has updated the primary and alternate means of communication from the facility to (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3) in the event of an emergency. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The Administrator/Designee will review the primary and alternate means of communication for the emergency preparedness plan and any negative findings will be immediately remedied. The results of the review will be addressed by the Quality Assurance Process Improvement committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** July 4th, 2024	
E 0039 SS=F	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2),			

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Bldg. --	483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or			

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	(B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or			

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	(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as			

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	needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.			

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	*[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct			

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	exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is			

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	community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a			

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	group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not	E 0039	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to have been affected by the alleged deficient practice. ***How other residents have the***	07/04/2024

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	accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: During record review with the Administrator on 06/11/24 at 12:41 p.m., the facility was unable to provide documentation of any exercises to test the emergency preparedness plan conducted wtihin the past 12 months. Based on interview at the time of record review, the Administrator advised that no exercises had been done during the time she had been at the facility, and she was not aware of any documentation of previous		***potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** All residents and staff have the potential to be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** The Administrator/Designee will participate in an annual full-scale exercise that is community based and a second full-scale exercise that is facility based within a 12-month period and provide documentation of any exercises to test the emergency preparedness plan. The facility will be collaborating with the Elkhart County Community Foundation to complete our two tabletop exercises. The facility's emergency preparedness plan will be updated accordingly. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The Administrator/Designee will review the tabletop/full-scale exercises and any negative findings will be immediately remedied and the facility emergency preparedness plan will be updated. The results of the	

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	exercises. This finding was reviewed with the Administrator and Maintenance Director during the exit conference at which time both stated the facility had not conducted an exercise during the time either had been at that facility.		review will be addressed by the Quality Assurance Process Improvement committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** July 4th, 2024	
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/11/24 Facility Number: 000034 Provider Number: 155086 AIM Number: 100274880 At this LSC survey, Woodland Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 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 II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and areas open to the corridor and battery operated smoke detectors in the resident rooms. The building is partially protected by a Type II EES 36 kW diesel-powered emergency generator. The facility	K 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective July 4th, 2024 to the life safety survey completed on June 11th, 2024. We respectfully request a paper review and will provide any additional information requested.	

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	has a capacity of 80 and had a census of 67 at the time of this survey Quality Review completed on 06/18/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection			

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	systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 2 of 7 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance	K 0222	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** The facility will have the exit door codes posted in a manner of which that staff and visitors can readily access the door to exit the premises in the case of an	07/04/2024

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	with 19.2.2.2.5.2. LSC 7.2.1.5.3 requires if provided, locks shall not require of a key, a tool, or special knowledge or effort for operation from the egress side This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Housekeeping/Maintenance Assistant on 06/11/24 at 09:52 a.m., the emergency exit door at the main entrance was marked as a facility exit, was magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Furthermore, the emergency exit door leading outside from the memory care unit was marked as a facility exit, magnetically locked, and could be unlocked entering a four digit code. When asking the the Housekeeper/Maintenance Assistant if they knew the code, he stated that he had a few codes in mind, but after trying to enter the codes they did not unlock the door. Furthermore, when asking three different staff members who work within and are designated for the memory care unit did not know the code for the emergency exit. Based on interview at the time of observations, the Housekeeper/Maintenance Assistant agreed that staff had no special knowledge of the code to enter for the emergency exit. He also confirmed that the code for the emergency exit at the front entrance was removed. The findings were reviewed with Maintenance Director and Administrator during the exit conference. 3.1-19(b)		emergency. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** The alleged deficient practice had the potential to affect all residents, staff and visitors. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** A quality assurance audit tool will be put into place to monitor means of egress to doors not equipped with a latch or a lock that requires a tool to open. Education provided to all staff. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** An audit will be completed by Maintenance/Designee on all door codes posted weekly for four weeks, then monthly for five months. Any negative findings will be immediately remedied, and Administrator notified. The results of the audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date that systemic changes will be completed:***	

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K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain 1 of 8 exit discharges in accordance with NFPA 101 Section 7.7 as required by Section 19.2.7. Section 7.7.1.1 state that the exit discharge shall be of the required width and size to provide all occupants with a safe access to a public way. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation with the Housekeeping/Maintenance Assistant on 06/11/24 during a tour of the facility from 09:50 a.m. to 12:18 p.m., the exit discharge leading from the memory care unit to the back of the building, next to the memory care dining room, had two plastic chairs stored in front of the emergency exit discharge. Based on interview at the time of observation, the Housekeeping/Maintenance Assistant acknowledged that the chairs were impeding the exit discharge from a designated emergency exit. He later confirmed that the door had an emergency exit sign. This finding was reviewed with the Maintenance Director and Administrator at the exit conference.	K 0271	It is the intent of the facility to maintain egress were provided with an unobstructed level walking surface. ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to be affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** Potentially all residents, staff and visitors in the memory care unit could be affected by the alleged deficient practice, no residents were identified. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:***	07/04/2024

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	3.1-19(b)		The Maintenance Director/Designee will audit all exit doors on the facility to ensure that there are no obstructions in front of the emergency exit discharge. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** An audit will be completed by Maintenance/Designee on all exit doors of the facility weekly for four weeks, then monthly for five months. Any negative findings will be immediately remedied, and Administrator notified. The results of the audits will be reviewed by the Quality Assurance Process Improvement meeting monthly. ***The date the systemic changes will be completed:*** July 4th, 2024	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete policy for the	K 0346	***What corrective action(s) will be accomplished for those***	07/04/2024

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	protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6, as required by LSC Section 19.3.4.5.1 which requires an automatic smoke detection system in accordance with Section 9.6. This deficient practice affects all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 06/11/24 at 9:55 a.m., a fire watch policy titled "Fire Watch Status" was produced. However, the plan did not address the following items: a) The time frame as to when a fire watch shall be conducted for an outage of more than 4 hours in a 24-hour period b) The provided plan did not address that fire watch shall be conducted by trained personnel c) The provided plan did not address personnel designated for fire watch shall have no other duties and solely assigned to fire watch Based on interview at the time of record review, the Maintenance Director acknowledged the missing elements of a fire watch and further stated that a fire watch would be implemented if "working on gas or something like that." This finding was reviewed with the Administrator and Maintenance Director during the exit conference 3.1-19(b)		***residents found to have been affected by the alleged deficient practice:*** No residents were found to have been affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** The facility policy has been updated to reflect a) the time frame as to when a fire watch shall be conducted (out-of-service 4hrs)…b) …that fire watch shall be conducted by trained personnel. C) …Personnel designated for fire watch shall have no other duties and solely assigned to fire watch. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** Education will be provided to all new hires and an audit will be completed by Maintenance/Designee weekly for four weeks, then monthly for five months. Any negative findings will	

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			be immediately remedied, and Administrator notified. The results of the audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date of systemic change will be completed:*** July 4th, 2024	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 5 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the	K 0353	It is the intent of the facility to maintain ease of accessible access to the automatic sprinkler system. ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient***	07/04/2024

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	type of construction. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation with the Housekeeping/Maintenance Assistant on 06/11/24 between 09:50 a.m. and 12:18 p.m., in the memory care unit, next to the double corridor doors leading into the service hall, one sprinkler head on the ceiling had an approximately 1/4" gap between the escutcheon plate and ceiling tile. Based on interview at the time of observation, the Housekeeping/Maintenance Assistant acknowledged the annular space and indicated that it was not smoke tight. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***practice:*** No residents were found to be affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** Potentially 20 residents, staff and visitors could be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** The ¼" gap was immediately filled with a fire protectant sealant between the escutcheon plate and ceiling tile. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** An audit will be completed by Maintenance/Designee to monitor for any gaps in fire rated doors or around sprinkler heads weekly for four weeks, then monthly for five months. Any negative findings will be immediately remedied, and Administrator notified. The results of the audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic change***	

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	155086	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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			will be completed: July 4th, 2024	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete policy for the protection of residents indicating procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2(4) states where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following: (a) Evacuation of the building or portion of the building affected by the system out of service (b)*An approved fire watch (c)*Establishment of a temporary water supply	K 0354	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to have been affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure***	07/04/2024

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	(d)*Establishment and implementation of an approved program to eliminate potential ignition sources and limit the amount of fuel available to the fire This deficient practice could affect all occupants in the facility. Findings include: Based on record review with the Administrator and Maintenance Director on 06/11/24 at 9:55 a.m., a fire watch policy titled "Fire Watch Status" was produced. However, the plan did not address the following items:. a) The time frame as to when a fire watch shall be conducted if the sprinkler system would be out-of-service for more than 10 hours in a 24-hour period b) The provided plan did not address that fire watch shall be conducted by trained personnel c) The provided plan did not address personnel designated for fire watch shall have no other duties and solely assigned to conduct fire watch Based on interview at the time of record review, the Maintenance Director acknowledged the missing elements of a fire watch and further stated that a fire watch would be implemented if "working on gas or something like that." This finding was reviewed with the Administrator and Maintenance Director during the exit conference 3.1-19(b)		***that the alleged deficient practice does not recur:*** The facility policy has been updated to reflect a) the time frame as to when a fire watch shall be conducted (out-of-service 10hrs) …b) …that fire watch shall be conducted by trained personnel. C) …Personnel designated for fire watch shall have no other duties and solely assigned to fire watch. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** Education will be provided to all new hires and an audit will be completed by Maintenance/Designee weekly for four weeks, then monthly for five months. Any negative findings will be immediately remedied, and Administrator notified. The results of the audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date of systemic change will be completed:*** July 4th, 2024	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

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	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable "K-class" fire extinguishers was inspected monthly. NFPA 10, the Standard for Portable Fire Extinguishers, Section 7.2.1.2 states Fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Section 7.2.4.4 states Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. This deficient practice could affect all kitchen staff. Findings include: Based on observation with the Maintenance Director on 06/11/24 at 11:15 a.m., the tag on the K-Class fire extinguisher in the kitchen did not indicate monthly inspections had been conducted. During record review with the Administrator at 11:25 a.m. documentation of monthly fire extinguishers indicated only ABC type fire extinguishers were inspected monthly an no documentation of monthly K-Class fire extinguisher inspections was provided. At time of interview the Maintenance Director stated he did monthly inspections of the K-Class fire extinguisher but was unable to provide documentation. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0355	It is the intent of the facility to securely store and maintain fire extinguishers. ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to have been affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** All residents, staff and visitors in the main dining area have the potential to be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** All fire extinguishers are inspected on a monthly basis as required by State requirements. A new tag was placed on the K class fire extinguisher and the tag was placed in a watertight bag to prevent the tag from being damaged and falling off again. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality***	07/04/2024

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			assurance program will be put into place: The Maintenance Director is responsible for completing the monthly inspections on all fire extinguishers. Those results will be reported to the Administrator and the Quality Assurance Process Improvement meeting monthly for six months. Any negative findings will be immediately remedied. ***The date the systemic change will be completed:*** July 4th, 2024	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the			

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	closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	1. Based on observation and interview, the facility failed to ensure 3 of 68 doors in the facility would completely resist the passage of smoke. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 0363	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Residents in rooms 400 and 222 were found to be potentially affected by the alleged deficient practice. ***How other residents that have the potential to be affected by the same defective practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected by the alleged deficient practice. ***What measures will be put into***	07/04/2024

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	impediment for the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or flames in window assemblies. This deficient practice could affect approximately 30 residents, as well as staff and visitors Findings include: Based on observation on 06/11/24 between 09:50 a.m. and 12:41 p.m. during a tour of the facility with the Housekeeping/Maintenance Assistant, the doors to resident rooms 400 and 222 had through & through door penetrations. Each penetration measured approximately 1/4 inches. Furthermore, the door to the janitors' closet, across from the unit 1/2 nurses' station had another door penetration that measured approximately 1/4 inches. Based on interview at the time of observation, the Housekeeping/Maintenance Assistant confirmed that the doors had the aforementioned penetrations and further agreed that the door was not smoke tight. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 kitchen corridor doors were		***place and what systemic changes will be made to ensure that the deficient practice does not recur:*** Doors 400, 222 and the janitor's closet have all had the ¼" penetration repaired. For section 3.1-19(b): All staff have been educated on the facility policy pertaining to "propping" doors. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The Maintenance Director/Designee is responsible for ensuring all doors are complete and not propped open. A weekly audit of complete doors and door closure will be completed, and any negative findings will be immediately remedied, and Administrator notified. The results of these audits will be reviewed in the Quality Assurance Process Improvement meeting for six months. ***The date the systemic changes will be completed:*** July 4th, 2024	

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	provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on observation with the Housekeeping/Maintenance Assistant on 06/11/24 from 09:50 a.m. to 12:48 p.m., the kitchen door leading to the service corridor was initially propped open with a service cart. At the first observation the Housekeeping/Maintenance Assistant removed the cart and closed the door. Later during the observation at the end of the tour, it was observed that the food cart had been again used to prop open the door. Based on interview at both observation times, the Housekeeping/Maintenance Assistant confirmed that the door had been propped open during the tour and stated that the door shouldn't be propped open. Findings were reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0511 SS=D 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	K 0511	It is the intent of the facility to	07/04/2024

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	failed to ensure 1 of 4 ectrical outlets in room 405 were protected according to LSC 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect approximately 4 residents and staff.. Findings include: Based on observations with the Housekeeping/Maintenance Assistant on 06/11/24 between 09:50 a.m. and 12:18 p.m., in resident room 405, behind the resident bed near the window, was missing a coverplate for the outlet. Based on interview at the time of observation, the Housekeeping/Maintenance Assistant acknowledged that the outlet was missing a coverplate. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		provide proper electrical installation. ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** The missing cover plate for the outlet in room 405 has been replaced. No other rooms identified as having the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected by the deficient practice. A facility-wide audit was completed to ensure that no other cover plates for outlets were missing. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** The Maintenance Director/Designee will audit 5 rooms weekly for four weeks, then 5 rooms monthly for five months to ensure compliance. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The Quality Assurance Audit Tool	

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			will be completed by the Maintenance Director/Designee weekly for four weeks; then monthly for five months. Those results will be submitted to the Administrator weekly and included in the Quality Assurance Process Improvement meeting monthly for six months. ***The date the systemic change will be completed:*** July 4th, 2024	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to conduct fire drills on each shift for 6 of 12 shifts. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include:	K 0712	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to be affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be***	07/04/2024

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	Based on records review with the Administrator and Maintenance Director on 06/11/24 at 10:10 a.m., the following shifts were missing documentation of a completed fire drill: a) A first and third shift fire drill for 2nd quarter of 2023. b) A first, second and third shift fire drill for 3rd quarter of 2023 c) A third shift fire drill in the fourth quarter of 2023. Based on interview at the time of record review, the Administrator acknowledged that the fire drills were missing. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 1 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 9:00 p.m. and 6:00 a.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on records review with the Administrator on 06/11/24 at 10:10 a.m., the fire drill form for a 2nd shift fire drill dated 12/13/23 conducted at 8:30 p.m. was conducted as a silent drill which had verification of the transmission of the fire alarm		***identified and what corrective action(s) will be taken:*** Potentially all residents, staff and visitors could be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** All fire drills have been completed as required since the Administrator and Maintenance Director started employment with the facility in March 2024 (Administrator) and April 2024 (Maintenance). This violation was from prior employees in those roles not following through with the State requirements for fire drills. We will continue to complete the tests as required. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The facility Maintenance Director is responsible for completing the facility fire drills. Any negative findings will be immediately remedied, and Administrator notified. Those results will be submitted and included in Quality Assurance Process Improvement meeting monthly for six months. ***The date the systemic change will be completed:*** July 4th, 2024	

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	signal the next day. The designated fire drill was not conducted within the time range healthcare facilities are able to use silent drills. Based on interview at the time of record review, the Administrator was unsure why the fire drill had been conducted as a silent drill when it was not supposed to. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)			
K 0761 SS=E Bldg. 01	1. Based on record review, observation and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen transfilling/storage room fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to	K 0761	It is the intent of the facility to provide annual inspection of the fire doors. ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to be affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** Potentially all residents, staff and visitors could be affected by the alleged deficient practice. ***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:***	07/04/2024

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	155086	A. BUILDING 01 B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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	assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants in the smoke compartment. Findings include: During record review with the Administrator on 06/11/24 at 11:00 a.m., the facility was unable to provide documentation for annual inspection of the oxygen transfilling/storage room fire door		The oxygen room fire door has been inspected and is current. The oxygen room fire door has been added to the list of annual fire door inspections. The roll down fire door/window between the kitchen and main dining room has been inspected and is scheduled for repairs on July 5th, 2024 by SafeCare. The roll down fire door/window has been added to the list of annual fire door inspections. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** An audit will be completed by Maintenance/Designee on all fire door inspections monthly for six months. Any negative findings will be immediately remedied, and Administrator notified. The results of the audits will be addressed by the Quality Assurance Process Improvement committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** July 4th, 2024	

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	assembly located near the main entrance. During a tour of the facility between 09:50 a.m. and 12:18 p.m., the fire rating label on the door was 1-1/2 hours. Based on interview at the time of record review, the Administrator agreed that documentation of an annual inspection was not available for the oxygen room fire door assembly in the last year. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire doors in accordance of NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the dining room and kitchen. Findings include: Based on observation during a tour of the facility with the Housekeeping/Maintenance Assistant on 06/11/24 between 09:50 a.m. and 12:18 p.m., there was one rolling fire door/window between the kitchen and dining area. During record review between 09:50 a.m. and 12:41 p.m., no			

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	documentation could be produced indicating that the rolling fire door had been inspected within the past 12 months. Based on interview at the time of record review, the Maintenance Director stated that a contracted company conducts the inspections and would have to contact them to retrieve the inspection if it was done. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect approximately 10 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Housekeeping/Maintenance Assistant on 06/11/24 between 09:50 a.m. and 12:18 p.m., a portable space heater was located in the housekeeping office ready for use. During record review between 09:50 a.m. and 12:41 p.m., the facilities policy stated that portable space heaters are prohibited within the facility. Based on interview at the time of observation, the	K 0781	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to be affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected by the alleged deficient practice, no residents were identified.	07/04/2024

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	Housekeeping/Maintenance Assistant acknowledged the space heater was in the office. He further clarified that the space heater is never used and does not have a maintenance program. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur:*** Space heater was immediately removed from the Housekeeping Directors office. Education was provided to all staff on the facility policy regarding space heater use. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** An audit will be completed by Maintenance/Designee on all space heater usage weekly for four weeks, then monthly for five months. Any negative findings will be immediately remedied, and Administrator notified. The results of the audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** July 4th, 2024	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

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	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect approximately 3 staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 06/11/24 at 09:54 a.m., in the front business office, next to the main entrance, there was a power strip, used to power electrical equipment, plugged into and supplied power by another	K 0920	***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:*** No residents were found to be affected by the alleged deficient practice. ***How other residents have the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken:*** Potentially all residents could be affected by the alleged deficient practice, no residents were identified. ***What measures will be put into place and what systemic changes will be made to ensure***	07/04/2024

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	power strip. Based on interview at the time of observation, the Housekeeping/Maintenance Assistant agreed that the power strips were daisy chained together and would work on getting them separated. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***that the alleged deficient practice does not recur:*** Power strip was immediately removed from the front office. Education was provided to all staff on the facility policy regarding power strip usage. ***How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place:*** An audit will be completed by Maintenance/Designee on all power strip usage weekly for four weeks, then monthly for five months. Any negative findings will be immediately remedied, and Administrator notified. The results of the audits will be reviewed by the Quality Assurance Committee monthly in the Quality Assurance Meeting. ***The date the systemic changes will be completed:*** July 4th, 2024	