STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING -- B. WING	02/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/06//2023 Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430 At this Emergency Preparedness survey, The Woodlands was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 108 and had a census of 72 at the time of this survey. Quality Review completed on 02/09/23	E 0000	K000 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 02/27/2023.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/06/2023 Facility Number: 000134 Provider Number: 155229 AIM Number: 100275430 At this Life Safety Code survey, The Woodlands was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000	K000 The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the plan of correction be considered the letter of credible allegation of compliance and request for a desk review (compliance) by 02/27/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Combs	Executive Director	02/24/2023

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	Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 108 and had a census of 72 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/09/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 exit doors from the front lobby restroom only contained one latching mechanism to release the door and open. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting	K 0211	• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; One of two latching mechanisms were removed from door on 2/20/2023 by maintenance director See Attachment (bathroomdoor,	02/27/2023

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	conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect visitors and staff that use the restroom. Findings include: Based on observation with the Maintenance Director on 02/06/23 at 1:15 p.m., the front lobby restroom exit door was equipped with two latching devices, a latching door turn knob and a separate deadbolt lock. Based on interview at the time of observation, the Maintenance Director agreed the front lobby restroom exit door was equipped with two latching devices. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		bathroomdoor1, bathroomdoor2). • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a facility wide audit was completed on 2/20/2023 and no other doors were effected. See Attachment (bathroomdooraudit) • what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Doors will be audited weekly by Maintenance Director or his/her designee for one month and then monthly times 6 months. See Attachment (bathroomdooraudit) • 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 Doors will be audited weekly by Maintenance Director or his/her designee for one month and then monthly times 6 months. Results of audit will be presented to quality assurance committee.	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier,			

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	or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure that 1 of 1 corridor door was self-closing and kept in the closed position. There was a self closer on the corridor door to the kitchen dishwashing room that did not function properly allowing the door to close but not latch. This deficient practice could affect staff and residents in the corridor by the kitchen dishwashing room. Findings include: Based on observation with the Maintenance Director on 02/06/23 at 1:45 p.m., the corridor door to the kitchen dishwashing room was equipped with a self-closing device, but the self-closing device would not fully close and latch to keep the door in the closed position. Based on interview at the time of observation, the Maintenance Director agreed the self-closing device on the door was not functioning properly as it did not allow the door to latch. The finding was reviewed with the Administrator and Maintenance Director during the exit conference.	K 0223	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Self-closing device on dishwasher room door was replaced on 2/17/2023 by maintenance director. See Attachment (doorclosure) • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Facility wide audit was conducted to check that all self-closing doors were functioning properly on 2/17/2023 (SEE ATTACHED selfcloser) with no issues noted. • what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur All self-closing doors will be	02/27/2023

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	3.1-19(b)		audited weekly for one month for proper door operation. Then monthly times 6 months. (SEE ATTACHED selfcloser). • 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 All self-closing doors will be audited weekly for one month for proper door operation. Then monthly times 6 months. (SEE ATTACHED selfcloser). Results will be presented to the quality assurance meeting.	
K 0353 SS=C 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	K 0353	what corrective action(s) will be	02/27/2023

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	failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 02/06/23 at 1:20 p.m., there was a spare sprinkler cabinet in the riser room that included 8 spare sprinklers; 2 of which were not in their own protected slot, being stored in the sprinkler cabinet. Based on interview at the time of the observation, the Maintenance Director agreed the spare sprinkler cabinet had spare sprinklers not in protected slots. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice; Sprinkler head storage cabinet installed and sprinklers in question stored in cabinet on 2/12/2023 See (sprinkcabinetpic1, sprinkcabinetpic2) • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Facility wide audit of sprinkler heads was completed on 2/12/2023 to ensure no other sprinkler heads were effected. See (sprinklerheadaudit) • what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Sprinkler heads will be monitored by maintenance director or his designee weekly for 1 month and then monthly times 6 months then quarterly to ensure all spare sprinkler heads are stored properly. See (sprinklerheadaudit) • 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 Sprinkler heads will be monitored by maintenance director or his designee weekly for 1 month and	

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			then monthly times 6 months then quarterly to ensure all spare sprinkler heads are stored properly. See (sprinklerheadaudit) Any issues found during monthly check will be presented to the quality assurance committee.	
K 0363 SS=D 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 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			

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	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.			
	Based on observation and interview, the facility failed to ensure 1 of 1 resident room corridor doors were 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 2 residents in room 62. Findings include: Based on observation with the Maintenance Director and Administrator on 02/06/23 at 2:10 p.m., the corridor door to resident room 62 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Door for room 62 was adjusted on 2/06/2023 and is closing appropriately. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a facility wide audit was completed on 2/07/2023 and no other corridor doors were found to have been affected. See Attachment (RmDoorAudit) • what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Corridor Doors will be audited weekly by Maintenance Director or his/her designee for one month then monthly for 6 months and then quarterly ongoing See Attachment (RmDoorAudit) to	02/27/2023

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			ensure proper functioning. • 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 Corridor Doors will be audited weekly by Maintenance Director or his/her designee for one month then monthly for 6 months and then quarterly ongoing See Attachment (RmDoorAudit) to ensure proper functioning. Results of audit will be presented to quality assurance committee.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls were protected to maintain the	K 0372	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	02/27/2023

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	smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 20 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 02/06/23 at 2:30 p.m. the following unsealed penetrations were discovered: In the attic smoke wall by resident room 57 there was a ½ inch unsealed gap around a conduit penetration and a 1 inch x 1 inch unsealed gap around another conduit penetration. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke walls contained unsealed penetrations. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Penetrations identified in smoke barrier walls were filled with fire caulk per regulation on 2/08/2023. (smokepic1,smokepic2,smokepic 3) • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a facility wide audit was completed on 02/08/2023 and no other smoke barrier walls were found to have been affected. • what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Smoke barrier walls will be audited monthly for 6 month to insure there are no penetrations. Then quarterly ongoing (smokebarrieraudit). • 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 Smoke barrier walls will be audited monthly for 6 months to insure there are no penetrations. Then quarterly ongoing (smokebarrieraudit). Results of audit will be presented to quality assurance committee.	

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K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 3 of 3 boilers had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 02/06/23 at 1:40 p.m, the three boilers in the facility did not have documentation to show when the boilers were inspected. Based on interview at the time of the observation, the Maintenance Director stated the inspection for the boiler could not be found and agreed the hot water heater inspection was past due and needed to be inspected. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)	K 0500	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Applications for 3 of 3 water heaters were filed with the state on 2/10/2023 (boilerinspect) • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Audit of facility maintenance rooms was conducted on 2/10/2023 to ensure no other boilers were effected. See (boileraudit). • what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Maintenance Director or his/her designee will audit facility weekly for 1 month, then monthly x 6 then quarterly ongoing to insure all boiler certificates are present and	02/27/2023

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			up to date (boileraudit). • 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 Maintenance Director or his/her designee will audit facility weekly for 1 month, then monthly x 6 then quarterly ongoing to insure all boiler certificates are present and up to date (boileraudit). Results of audits will be presented to quality assurance committee.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 fire door 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	K 0761	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Fire doors and oxygen room were inspected on 2/15/2023 by maintenance director with no issues noted See Attachment (firedoor.oxygenaudit). • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Audit of facility records was conducted by maintenance on 2/20/2023 to ensure all paperwork was present.	02/27/2023

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	155229	A. BUILDING 01 B. WING	02/06/2023

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WOODLANDS THE	3820 W JACKSON ST MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 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 residents in that area. Findings include: Based on record review with the Maintenance Director on 02/06/23 no documentation of an annual inspection for the fire door for the oxygen		• what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Maintenance Director or his/her designee will audit facility documentation weekly for 1 month, monthly x 6 then quarterly ongoing to insure all documentation is present and up to date on fire doors and oxygen room. See Attachment (firedoor.oxygenaudit). • 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 Maintenance Director or his/her designee will audit facility documentation weekly for 1 month, monthly x 6 then quarterly ongoing to insure all documentation is present and up to date on fire doors and oxygen room. Results of audits will be presented to quality assurance committee. See Attachment (firedoor.oxygenaudit).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155229	A. BUILDING 01 B. WING	02/06/2023

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	room was available for review. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspection was not completed within the last year. This finding was reviewed with the Maintenance Director at the exit conference. 3.1-19(b)			