

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/14/15</p> <p>Facility Number: 000307 Provider Number: 155666 AIM Number: 100285660</p> <p>At this Life Safety Code survey, Wesley Healthcare and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>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 hard wired smoke detection in the corridors, areas open to the corridors and in resident rooms. The facility has a capacity of 79 and had a census of 47 at the time of this survey.</p>	K 000	<p>This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the state allegations. Wesley Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare requests paper compliance for K050, K062, and K147. There was no actual citation of harm to any of the residents.</p>	

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/14/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 050 SS=F Bldg. 01	<p>All areas where residents have customary access were sprinklered. The facility had two detached metal shipping cargo containers providing facility services including the storage of medical records and maintenance parts that were not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report" documentation with the Director of Environmental Services and the</p>	K 050	<p>K050 NFPA 101 life safety code standard</p> <p>It is the practice of this facility to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. A new fire drill procedure and schedule have been made to ensure drills are being conducted on both shifts throughout the year.</p> <p>All residents have the potential to</p>	04/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2015
NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
K 062 SS=C Bldg. 01	<p>Maintenance Director on 04/14/15 at 9:30 a.m., there was a record shown for a third shift fire drill for the first quarter of 2015, but the drill was conducted at 9:00 p.m. Based on interview during record review, the Director of Environmental Services and the Maintenance Director stated the third shift is from 10:00 p.m. to 6:00 a.m. and confirmed the paper work for the aforementioned drill was marked as a third shift but took place at 9:00 p.m. one hour before third shift started.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two</p>	K 062	<p>be effected; however there was no actual harm to none.</p> <p>Maintenance director will be in-serviced on frequency of and varying times of fire drills.</p> <p>Fire drills will be monitored by the administrator /designee monthly x6 months and report to QA monthly.</p> <p>Date of compliance April 30, 2015</p> <p>K062 NFPA 101 life safety code standard</p> <p>It is the practice of this facility to continue to maintain the automatic sprinkler system and ensure that there are spare sprinkler heads located in the cabinet. Extra sprinkler heads have been ordered from Koorsen.</p> <p>All residents have the potential to be effected; however there was no actual harm to none.</p>	04/30/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2015	
NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
K 147 SS=B Bldg. 01	<p>sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services and the Maintenance Director on 04/14/15 at 11:30 a.m., system sprinkler heads included standard response and quick response pendants but there were no standard response pendants and only one quick response pendant in the spare sprinkler cabinet. Based on interview at the time of observation, the Maintenance Director acknowledged the lack of the correct type of spare sprinkler heads.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 wet location in the Dialysis Equipment Room had a working ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517,</p>	K 147	<p>The maintenance director will be in-serviced on the importance of having spare sprinkler heads available at all times.</p> <p>The maintenance director/designee will check the spare sprinkler heads to ensure the correct type are available at all times. This will be done monthly with results taken to QA meetings.</p> <p>Date of compliance April 30, 2015</p> <p>K147 NFPA 101 life safety code standard</p> <p>The maintenance director replaced the electrical receptacle in the dialysis room on 4/21/15</p>	04/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2015	
NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice was not in a resident assessable area but can affect up to 3 staff using the Dialysis Equipment Room.</p> <p>Findings include:</p> <p>Based on observation and testing during the tour of the facility with the Director of Environmental Services and the Maintenance Director on 04/14/15 at 10:30 a.m., there was an electric receptacle located in the Dialysis Equipment Room on the wall within three feet of the water spout of a sink. The receptacle had a sticker on it stating it was GFCI protected, but the receptacle failed to trip when using a GFCI tester. Based on interview at the time of observation and testing, The Maintenance</p>		<p>with the appropriate GFCI protection.</p> <p>All residents have the potential to be effected; however there was no actual harm to none.</p> <p>The maintenance director will be in-serviced on importance of having proper receptacles with the GFCI protection.</p> <p>The maintenance director will check all electrical receptacles to ensure they have the proper protection and report to the QA meeting.</p> <p>Date of compliance April 30, 2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/14/2015
NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	Director acknowledged the electrical receptacle failed to trip when tested. 3.1-19(b)				