

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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
K0000	<p>A Life Safety Code Recertification, State Licensure Survey, and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/09/12</p> <p>Facility Number: 000221 Provider Number: 155328 AIM Number: 100267620</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code and Quality Assurance Walk-thru survey, Westpark 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>	K0000	<p>The Preparation or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.</p> <p>We respectfully request a desk review and this Plan of Correction serve as our allegation of compliance.</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:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/09/2012
NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712		
(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>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors with battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 115 and had a census of 81 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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
K0018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 sets of double doors to the corridor were equipped with positive latches and latched into the door frame. This deficient practice could affect residents, as well as staff and visitors in the dining room which seats about fifty people, and the Resident Snak Shoppe which seats four people.</p> <p>Findings include:</p> <p>Based on observations on 10/09/12 between 10:30 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Director, the two sets of double</p>	K0018	<p>K 018 Smoke detectors have been installed in the resident snack shop and the dining room to meet the requirement. An inspection was completed to ensure facility rooms are equipped with smoke detection system. Smoke detector were installed as indicated by the inspection. The Maintenance Director was re-educated regarding areas of the facility that require smoke detection. Audits will be completed after any construction or remodeling work to ensure the facility is equipped with smoke detection devices as needed. Audits will be ongoing. Smoke detection devices will be installed as indicated by the audits. The audits will be reviewed by the Administrator/Designee to ensure compliance. Results of audits will</p>	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/09/2012
NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712		
(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	
	doors from the corridor into the main Dining Room, and the doors from the corridor into the Resident Snak Shoppe would latch into each other, however, both sets of double doors would not latch into their respective door frames. This was acknowledged by the Maintenance Director at the time of each observation.  3.1-19(b)		be forwarded to the Quality Assurance (QA) Committee monthly x 6 months for further review and recommendations. Compliance date 11-2-12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/09/2012	
NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712			
(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			
K0025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 smoke barrier walls provided at least a one half hour fire resistance rating. This deficient practice could affect up to 11 residents, as well as staff and visitors in the E and F halls.</p> <p>Findings include:</p> <p>Based on observation on 10/09/12 at 12:45 p.m. during a tour of the facility with the Maintenance Director, the smoke barrier wall in the attic above the northeast corridor smoke barrier doors had five penetrations through the wall which were not fire stopped. The penetrations were around conduits, wires, and sprinkler pipes ranging in size</p>	K0025	H 025 The five penetrations through the smoke barrier wall have been have been repaired with a fire rated sealant. An inspection was conducted to ensure penetrations through smoke barrier walls are fire stopped. Repairs were made as indicated by the inspection. The Maintenance Director was re-educated regarding penetrations through smoke barrier walls. Audits will be completed after there is any construct/contractor work to ensure penetrations through smoke barrier walls are fire stopped. The audits will be reviewed by the Administrator/Designee to ensure compliance. Results of audits will be forwarded to the Quality Assurance (QA) Committee monthly x 6 months for further review and recommendations. Compliance date 11-2-12	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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>from one fourth inch to six inches. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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
K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 hazardous area room doors, such as a room over 50 square feet in size containing a large amounts of combustible material, was equipped with a self closing device on the door. This deficient practice could affect two residents that reside in the E hall, as well as any other residents, staff and visitors while traversing the E hall.</p> <p>Findings include:</p> <p>Based on observation on 10/09/12 at 11:05 a.m. during a tour of the facility with Maintenance Director, the Central Supply Room was over fifty square</p>	K0029	<p>K 029 A self closing device was installed on the central supply room door. An audit conducted to ensure hazardous room doors are equipped with self closing devices. Self closing door devices were installed as indicated by the audit. The Maintenance Director was re-educated regarding self closing devices on hazardous room doors. Audits will be completed after any construction or remodeling work to ensure self closing door devices are installed if needed. Self closing devices will be installed as indicated by the audits. The audits will be reviewed by the Administrator/Designee to ensure compliance. Results of audits will be forwarded to the Quality Assurance (QA) Committee monthly x 6 months for further review and recommendations. Compliance date 11-2-12</p>	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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>feet in size and had over 30 cardboard boxes stored within. The door to this room was not provided with a self closing device. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/09/2012	
NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712			
(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			
K0062 SS=E	<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 ensure 4 of over 500 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect 9 residents, as well as staff and visitors while exiting the F hall east exit door and kitchen staff while in the kitchen.</p> <p>Findings include:</p> <p>Based on observations on 10/09/12 between 10:30 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Director, the sprinkler head under the canopy overhang outside the F hall east exit door was covered</p>	K0062	<p>K 062 The sprinkler head under the F hall canopy and the 3 sprinkler heads in the kitchen have been replaced. An inspection was completed to ensure sprinkler heads are free of corrosion. Sprinkler heads were replaced as indicated by the inspection. The Maintenance Director was re-educated regarding corroded sprinkler heads. Weekly audits will be conducted on sprinkler head to ensure they are free of corrosion. Audits will be ongoing. Sprinkler heads will be replaced as indicated by the audits. The audits will be reviewed by the Administrator/Designee to ensure compliance. Results of audits will be forwarded to the Quality Assurance (QA) Committee monthly x 6 months for further review and recommendations. Compliance date 11-2-12</p>	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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>with corrosion, furthermore, three sprinkler heads in the kitchen over the dishwasher and steamer were covered with corrosion. This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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
K0066 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where smoking was allowed. This deficient practice could affect mostly staff in an area where only staff is allowed to smoke. Two staff persons were smoking at the time of observation.</p> <p>Findings include:</p>	K0066	K 066 Proper containers to dispose of cigarette butts are provided in designated smoking areas. The employee smoking area was moved to ensure it is away from the dryer vents and 15 feet away from the gas meter. An audit of designated smoking areas was conducted to ensure proper disposal containers are provided and 15 feet away from a gas meter. Identified areas were provided with proper containers and or moved as indicated. Staff have been re-educated on the new smoking area. Audits will be conducted 5 x weekly for 6	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/09/2012
NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712		
(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>Based on observation on 10/09/12 at 10:40 a.m. during a tour of the facility with the Maintenance Director, the smoking area outside the service hall exit was not provided with proper containers for the disposal of cigarette butts. About fifty cigarette butts were in an open ashtray on top of a trash receptacle, and at least five cigarette butts were mixed in with the paper trash within the trash receptacle. Furthermore, the smoking area was within three feet of a large laundry dryer exhaust vent which had a three foot strip of lint where 10 cigarette butts had been thrown. Also, the smoking area was within fifteen feet of the facility's gas meter. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3-1.19(b)</p>		<p>months by the Maintenance Director/designee to ensure employees are in the designated areas when smoking. The audits will be reviewed by the Administrator/Designee to ensure compliance. Results of audits will be forwarded to the Quality Assurance (QA) Committee monthly x 6 months for further review and recommendations. Compliance date 11-2-12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/09/2012	
NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712			
(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
K0130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 5 of 6 fuel fired water heaters had current inspection certificates to ensure the boilers and water heater were in safe operating condition. NFPA 101 in 19.1.1.3 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, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 10/09/12 between 10:30 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance Director, the inspection certificates located next to the five fuel fired water heaters had expiration dates of 08/26/11. During an interview at the time of each observation, the Maintenance Director acknowledged the expiration dates on water heaters</p>			K0130	<p>K 130 The fuel fired water heaters water heaters have current inspection certificates. An audit was conducted to ensure gas fired water heaters have current inspection certificates. The Maintenance Director was re-educated regarding current inspection certificates on gas fired water heaters. Monthly audits of water heater certificates will be conducted to ensure they are current. The audits will be reviewed by the Administrator/Designee to ensure compliance. Results of audits will be forwarded to the Quality Assurance (QA) Committee monthly x 6 months for further review and recommendations. Compliance date 11-2-12</p>		11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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
	and said he was not aware of the water heaters being inspected since the expiration dates.  3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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
K0147 SS=E	<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 power strips and extension cords were not used as a substitute for fixed wiring in 3 of 7 smoke compartments. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect residents, staff and visitors while in the Physical Therapy area where three residents were at the time of observation, but, it could accommodate up to eight residents, also, staff while in the laundry room and Medical Records Office where one staff person was in each room at the time of each observation.</p> <p>Findings include:</p> <p>Based on observations on 10/09/12 between 10:30 a.m. and 1:00 p.m. during a tour of the facility with the Maintenance</p>	K0147	<p>K 147</p> <p>The power strip has been removed from the therapy office, medical record office, and the laundry room.</p> <p>An audit was conducted to ensure there are no power strips or extension cords that are being used for fixed wiring. Power strips or extension cords were removed if indicated that they were being used for fixed wiring.</p> <p>The Maintenance Director was re-educated extension cords and power strips. Weekly audits will be conducted for 6 months to ensure extension cords or power strips are not being used for fixed wiring and will be removed as needed.</p> <p>The audits will be reviewed by the Administrator/Designee to ensure compliance. Results of audits will be forwarded to the Quality Assurance (QA) Committee monthly x 6 months for further review and recommendations.</p> <p>Compliance date 11-2-12</p>	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
--	--

(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>Director, the Physical Therapy office had a microwave and refrigerator plugged into a power strip, the laundry room had an extension cord used to provide a light source in the dryer room, and the Medical Records Office had an extension cord plugged into a window air conditioner unit. This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p>			