

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2012
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NAME OF PROVIDER OR SUPPLIER WESTPARK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222
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K0000	<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: 02/03/12</p> <p>Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westpark Healthcare 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 consisted of two sections: the original section determined to be Type III (200) construction and the Addition, determined to be Type V (000) construction, both fully sprinklered with a fire alarm system with smoke detection in the corridors and all areas open to the</p>	K0000		
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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.

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	<p>corridor. Smoke detection was not provided in resident rooms. The entire facility was surveyed as Type V (000) construction. The facility has a capacity of 89 and had a census of 57 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/07/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0029 SS=E	<p>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 2 of 8 doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch each door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen entry door by the dishwasher and by the serving window .</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 12:50 p.m. on 02/03/11, the kitchen entry door by the dishwasher and by the serving window are not equipped with a positive latching device to latch each door into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the kitchen entry door by the dishwasher and by the serving window are not equipped with a positive</p>	K0029	<p>K029:</p> <p>(1.) Both kitchen entry doors will have positive latching devices equipped by 2/17/12.</p> <p>(2.) Any resident could have potentially been affected. Both kitchen entry doors will have positive latching devices equipped by 2/17/12.</p> <p>(3.) The systemic change that the facility has made is installing positive latching devices by 2/17/12 to ensure that the doors will latch each time they are closed.</p> <p>(4.) Maintenance will "inspect" the positive latching devices during their weekly maintenance rounds to ensure that they are functioning properly.</p>	02/17/2012			

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	latching device to latch each door into the door frame. 3.1-19(b)			
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K0045 SS=E	<p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure lighting for 1 of 7 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any resident, staff or visitor if needing to exit the facility from the Northeast exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 12:50 p.m. on 02/03/11, the exit means of egress from the Northeast exit is equipped with one light fixture with one bulb. Based on interview at the time of observation, the Maintenance Supervisor acknowledged only one light fixture with one bulb was provided at the Northeast exit.</p> <p>3.1-19(b)</p>	K0045	<p>K045:</p> <p>(1.) The Northeast exit will be equipped with a new two bulbfixture by 2/17/12.</p> <p>(2.) Any resident exiting through the Northeast exit could havepotentially been affected. The Northeast exit will be equipped with a new bulbfixture by 2/17/12.</p> <p>(3.) The systemic change that the facility has made isinstalling a new two bulb fixture by 2/17/12.</p> <p>(4.) Maintenance will "inspect" the two bulb fixture duringtheir weekly maintenance rounds to ensure that they are functioning properly.</p>	02/17/2012	

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K0048 SS=E	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Fire Prevention and Protection" during record review with the Maintenance Supervisor from 9:20 a.m. to 11:20 a.m. on 02/03/12, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in</p>	K0048	<p>K048:</p> <ol style="list-style-type: none"> (1.) A new policy is in place to address the use of both the ABC Fire Extinguishers and the K Class Fire Extinguisher. Additionally, dietary staff will be trained and in-serviced on the proper use and activation of the fire suppression systems and the K Class Fire Extinguisher. (2.) Any resident could have potentially been affected. A new policy has been put into place to address the use of both types of fire extinguishers and staff has been trained and in-serviced on the proper use and activation of the fire suppression systems and the K Class Fire Extinguisher. (3.) The systemic changes the facility has made include amending the fire safety plan to address the use of both types of fire extinguishers, as well as the fire suppression systems. All Fire/Disaster manuals throughout the building have been updated with these policy amendments. Dietary staff will be trained 	02/17/2012			

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	<p>relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>andin-serviced on the proper use and activation of the fire suppression system andthe K Class Fire Extinguisher by 2/17/12.</p> <p>(4.) The amended safety plan and training will be included inthe annual Fire/Disaster annual in-service from this point on.</p>	

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K0050 SS=C	<p>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 conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:20 a.m. to 11:20 a.m. on 02/03/12, third shift fire drills conducted on 03/24/11, 09/13/11 and 12/16/11 were conducted at, respectively, 6:00 a.m., 6:30 a.m. and 6:25 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>	K0050	<p>K050:</p> <p>(1.) From this point on third shift fire drills will beconducted at unexpected times under varying conditions. In the future, fire drills that are conductedon third shift will be conducted at least two hours earlier or two hours laterthan the time that the prior fire drill was conducted.</p> <p>(2.) Any resident could have been potentially affected. In the future, fire drills that are conductedon third shift will be conducted at least two hours earlier or two hours laterthan the time that the prior fire drill was conducted.</p> <p>(3.) The systemic change that the facility has made isensuring that future fire drills on third shift be conducted at least two hoursearlier or two hours later than the time that the</p>	02/17/2012			

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			prior fire drill was conducted. (4.) The Administrator/Owner will monitor the corrective action at QA for the next four quarters to ensure that the fire drills are being conducted at unexpected times under varying conditions.		

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K0052 SS=E	<p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review, interview and observation; the facility failed to ensure documentation of annual functional testing for 3 of 40 smoke detectors was maintained. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors are tested annually. This deficient practice could affect any residents, staff or visitor in the vicinity of the West Hall furnace room, the Equipment room by the Therapy room and the Therapy room closet.</p> <p>Findings include:</p> <p>Based on review of AADCO Alarms & Communication Systems "Inspection and Testing" documentation dated 02/21/11 with the Maintenance Supervisor during record review from 9:20 a.m. to 11:20 a.m. on 02/03/12, duct detectors in the West Hall furnace room, the Equipment room by the Therapy room and the Therapy room closet were not included in the listing of facility smoke detectors functionally tested. Based on observation during a tour of the facility with the</p>	K0052	<p>K052:</p> <p>(1.) AADCO Alarms and Communication Systems were here on 2/6/12 and inspected, tested, and documented the inspection of the three smokedetectors in question. All 40 smokedetectors will be tested and documented as tested annually.</p> <p>(2.) Any resident could have potentially been affected. All 40 smoke detectors will be tested and documented as tested annually.</p> <p>(3.) The systemic change that the facility has made is contacting AADCO Alarms and Communication Systems and alerting them that they must include duct detectors in the West Hall furnace room, the Equipment Room by the Therapy Room, and the Therapy Room closet in the listing of facility smoke detectors functionally tested annually.</p> <p>(4.) The corrective action will</p>	02/17/2012			

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	<p>Maintenance Supervisor from 11:20 a.m. to 12:50 p.m. on 02/03/12, a duct detector was observed in the West Hall furnace room, in the Equipment room by the Therapy room and in the Therapy room closet. Based on interview at the time of record review and at the time of observation, the Maintenance Supervisor acknowledged each smoke detector located in the West Hall furnace room, the Equipment room by the Therapy room and the Therapy room closet were not functionally tested within the last year.</p> <p>3-1.19(b)</p>		<p>be monitored by the Maintenance Supervisor. The maintenancesupervisor will be responsible to reviewing the documentation of AADCO Alarmsand Communication Systems annually prior to them leaving after their annualtesting.</p>	