

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2012
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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802
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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: 10/25/12</p> <p>Facility Number: 000139 Provider Number: 155234 AIM Number: 100266410</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westridge Health Care 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 (000) construction and was fully</p>	K0000	<p>Please find enclosed the plan of correction for the survey ending October 25, 2012. Due to the scope and severity of the survey findings, please also find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me. Respectfully, Sally Robertson Administrator</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.

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	<p>sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 66 and had a census of 54 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered.</p> <p>All areas providing facility services were sprinklered, except the detached laundry and maintenance storage areas.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/31/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 8 doors to a hazardous area, such as the kitchen and soiled linen collection rooms were held open only by devices allowing them to close upon activation of the fire alarm system. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p>	K0021	<p><u>Kitchen Door</u>: 1. The draft that held the kitchen door open was assessed. 2. Unnecessary ventilation that created negative air pressure holding the kitchen door open was corrected 11/12/12. 3. The self-closure device on the kitchen door was adjusted to allow the kitchen door to close properly 10/29/12. 4. The Administrator/designee will monitor once a week for four weeks, then every other week for two months, then monthly thereafter for three months. 5. Any issues the Administrator/designee discovers will be addressed immediately. 6. Findings will be discussed during the monthly Quality Assurance meeting. Completion Date: 11/12/12 <u>South Shower Room Door</u>: 1. The rack that was used to prop the shower room door open was removed 11/5/12. 2.</p>	11/14/2012	

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	<p>a. Based on observation with the administrator on 10/25/12 at 2:00 p.m., the self closing door providing access from the center smoke compartment into the kitchen was tested twice with the administrator. Each time the door failed to self close. It appeared a draft between the kitchen and corridor could not be overcome by the door to allow closing. The door failed to close again upon activation of the fire alarm on 10/25/12 at 4:50 p.m. The administrator agreed at the time of observations the door was not operating as it should.</p> <p>b. Based on observation with the administrator on 10/25/12 at 4:25 p.m., the self closing door providing access from the center smoke compartment to the shower room collection site for soiled linen receptacles was prevented from closing by a rack attached to the wall behind the door. The administrator agreed the rack was preventing the door from self closing.</p> <p>3.1-19(b)</p>		<p>The Administrator/designee performed an audit of all doors in the facility to ensure no doors were propped open or that there were items being used by staff to prop doors open 11/5/12. 3. All staff members were instructed, via an in-service, that doors are not to be propped open. Date of completion 11/14/12. 4. The Administrator/designee will continue to monitor staff compliance during daily rounds. Noncompliance will be corrected immediately. 5. Staff member who do not comply will receive disciplinary action. 6. Findings will be discussed in the monthly Quality Assurance meeting. Completion Date: 11/14/12</p>				

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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 provide automatic closers for doors providing access to 1 of 8 hazardous areas such as a combustibile materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 10 or more residents in the north smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 10/25/12 at</p>	K0029	<ol style="list-style-type: none"> Room 222 is a resident room and not a storage room, and as such, does not require a self-closing device. Activity staff members have been educated on proper locations to store items collected for fundraisers intended to raise funds for resident activity events. The items in Room 222 were boxed up and stored in the detached garage until weather permitted the yard sale to be conducted. Completion date 11/2/12. All staff members have been educated on the proper locations available to store items. Completion date 11/14/12. 	11/14/2012

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	<p>4:15 p.m., resident room 222 was used for the storage of fabric, paper, plastic and other combustible materials. The door was not equipped with a self closing device. The administrator said at the time of observation, the items were collected for a yard sale which had been postponed for two or more weeks.</p> <p>3.1-19(b)</p>		<p>5. The Administrator/designee will continue to monitor for improper storage during daily rounds.</p> <p>6. Improper storage of items will be discussed with the appropriate department manager during morning meetings, with correction to be conducted immediately.</p>	

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure egress for 1 of 5 smoke compartments was arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 requires the means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use. This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 10/25/12 at 2:10 p.m., a two by six foot section of the floor located in the path of egress between the 100 hall and the rest of the facility was under repair which had entailed</p>	K0038	<ol style="list-style-type: none"> Items left behind by the contractor were removed. The contractor returned and leveled the concrete flooring November 1, 2012. Tile was replaced and repair was completed November 12, 2012. 	11/12/2012
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	<p>digging out the concrete floor. The work left the surface uneven and unsafe for travel by residents and had been cordoned with caution tape leaving a clear pathway of two and one half feet. The contractor arrived on 10/25/12 at 3:15 p.m. and did some grinding on the concrete. He then disappeared, leaving a pile of plastic sheeting and other equipment in the work area effectively diminishing the corridor width to less than three feet. The administrator was asked on 10/25/12 at 4:30 p.m. where the contractor had gone. She could not say. The staff was asked to clear the pathway to allow egress access by residents.</p> <p>3.1-(19)</p>			

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K0050 SS=F	<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 quarters. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records on 10/25/12 at 1:55 p.m., there were no records of fire drills for any shift during the fourth quarter of 2011. The administrator acknowledged fire drill records were not complete and said she had provided all fire drill documentation.</p> <p>3.1-9(b) 3.1-51(c)</p>	K0050	<ol style="list-style-type: none"> All monthly Fire Drills will be conducted. Starting with the October 2012 Fire Drill, all Fire Drill records will be stored both in the Administrator's office and a copy in the appropriate Maintenance binder. The Administrator/designee will monitor compliance monthly. In the absence of Maintenance personnel the Administrator/designee will be responsible to conduct the Fire Drill. Compliance 10/31/12. 	10/31/2012			

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 cylinders of nonflammable gases in the oxygen storage room were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice affects visitors staff and 10 or more residents in the north smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K0076	<ol style="list-style-type: none"> All e-cylinders have been properly stored in a cylinder stand in the Oxygen Storage Room. No e-cylinders will be stored out of the stand. All nursing staff members have been in-serviced on the proper storage of e-cylinders. Completion date November 14, 2012. The Administrator/Designee monitors the Oxygen Storage Room during daily rounds. Improper storage will be corrected immediately. 	11/14/2012

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	<p>administrator on 10/15/12 at 2:35 p.m., three oxygen e-cylinders were stored without support in the oxygen supply storage room with five liquid oxygen containers. The administrator agreed at the time of observation, the cylinders should have been supported.</p> <p>3.1-19(b)</p>			

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the required means of egress and fire protection features were continuously maintained during repair to concrete flooring in 1 of 5 smoke compartments. LSC 4.6.10.1 allows buildings to be occupied during repair only where the means of egress and fire protection features are continuously maintained. This deficient practice affects visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 10/25/12 at 2:10 p.m., a two by six foot section of the floor located in the path of egress between the 100 hall and the rest of the facility was under repair which had entailed digging out the concrete floor. The work left the surface uneven and unsafe for travel by residents and had been cordoned with caution tape leaving a clear pathway of two and one half feet</p>	K0130	<p>The fire protection features such as corridor smoke detectors and sprinkler heads will be protected in the following manner during periods in which work is being conducted that may affect the fire protection system negatively:</p> <p>a. The work area will be tented with plastic sheeting.</p> <p>b. Plastic bagging will be placed over corridor smoke detectors and sprinkler heads. The bagging will be held in place with plastic zip ties. The plastic bagging will be large enough to engulf the whole smoke detector/sprinkler head.</p> <p>c. A Fire Watch will be implemented for the area.</p> <p>The posted boiler certificate of inspection was for boiler IN312472 which was a AO Smith FT Boiler built in 2010. This certificate stated it expired 10/21/2012. The Boiler AO Smith IN312472 was</p>	11/12/2012			

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	<p>for residents and staff to travel. A contractor came in on 10/25/12 at 3:15 p.m., covered himself in plastic and began grinding the concrete. The corridor was infused with dust despite the plastic covering the workman. The administrator asked him to do more to prevent the dust which could cover the sprinklers and smoke detectors in the area. He agreed, then disappeared leaving a pile of plastic sheeting and other equipment in the work area effectively diminishing the corridor width to two and one half feet. The administrator was asked what the policy was for maintaining the fire protection features such as the corridor smoke detectors and sprinkler heads during the repairs. She could not say. The administrator was asked on 10/25/12 at 4:30 p.m. where the contractor had gone and she did not know. The staff was asked to clear the pathway to allow egress access by residents.</p> <p>3.1-(19)</p> <p>2. Based on observation, record</p>		<p>scrapped, meaning it is no longer in use and has been removed. Since it is not in use it does not require inspections.</p> <p>The boiler in use is a Lochinvar Boiler IN0295574. It was inspected 9/25/12 by Zurich Services Corporation inspector Benjamin Lawrence. It passed inspection and inspection won't be due again until 9/25/14. The certificate for this inspection has not arrived yet from the state, however a copy of an email and a report from Zurich Services Corporation stating the above has been posted in the boiler room 11/12/12.</p>	

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	<p>review, and interview; the facility failed to ensure 1 of 1 boiler certificates of inspection was not expired. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects the center smoke compartment with 10 or more residents.</p> <p>Findings include:</p> <p>Based on observation of the boiler certificate of inspection on 10/25/12 at 4:10 p.m., the posted certificate of inspection for boiler #312472 had expired 10/21/12. The administrator said at the time of observation, she was unaware the certification had expired and no inspection was currently scheduled.</p> <p>3.1-19(b)</p>				

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage and transfer rooms was arranged to allow oxygen transfer in the room with the door closed. This deficient practice affects visitors staff and 10 or more residents in the north smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 10/15/12 at 2:35 p.m., the oxygen transfer room was identified by the administrator. The room was filled to capacity with liquid</p>	K0143	<p>1. All nursing staff members were in-serviced on properly filling oxygen tanks and portables with the Oxygen Storage Room door closed.</p> <p>2. The Director of Nursing/designee will monitor the filling of oxygen tanks and portables 5 times a week for 3 weeks, then 3 times a week for three weeks. Results will be discussed during the monthly Quality Assurance Meeting. It will be determined at the monthly Quality Assurance Meeting if compliance has been achieved</p>	11/14/2012	

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	<p>oxygen tanks and oxygen cylinders. The administrator was asked at the time of observation, how staff could fill portable tanks without exposing residents to the procedure. She agreed the room was too full to allow staff to enter and close the door to separate the transfer activity from the resident corridor.</p> <p>3.1-19(b)</p>		<p>and if additional monitoring and education is required.</p> <p>3. All oxygen tanks are to be stored appropriately.</p> <p>4. All empty oxygen tanks are to be removed to the outside storage area.</p> <p>5. The Oxygen Storage Room will be monitored daily by the Administrator/designee to ensure tanks are stored appropriately, empty tanks are taken to the outside storage area and there is adequate room for staff members to be able to occupy the room with the door closed when filling tanks.</p> <p>6. The e-cylinder stand and the O2 tanks were arranged 11/12/12 to allow oxygen transfer in the room with the door closed.</p>		

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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 1 of 1 flexible cords was not used as a substitute for fixed wiring. NFPA 70, the National Electrical Code, 1999 Edition, 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 staff, visitors and 10 or more residents in the north and center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 10/25/12 at 4:25 p.m., an extension cord was plugged into the wall beside the bed in resident room 220. The administrator said at the time of observation, she didn't know the power strip was in use.</p> <p>3.1-19(b)</p>	K0147	<ol style="list-style-type: none"> The extension cord in Room 220 was removed 10/26/12. A room by room audit was conducted by the Administrator to ensure other inappropriate extension cords were not in use 11/8/12. All staff member are to be in-serviced in the use/improver use of extension cords/power strips. Completion date 11/14/12. The Maintenance Director/designee, and in the absence of a Maintenance Director, the Administrator/designee shall audit resident rooms for extension cords weekly for four weeks, then monthly thereafter. 	11/14/2012	

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