

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  03/17/2015
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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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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: 03/17/15</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 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</p>	K 000	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
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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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K 038 SS=E Bldg. 01	<p>equipped with battery powered smoke detectors. The facility has the capacity for 66 and had a census of 44 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 Dennis Austill, Life Safety Code Specialist on 03/23/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p> <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 Based on observation and interview, the facility failed to ensure exit discharges from 3 of 5 smoke compartments were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4</p>	K 038	The concrete exit discharge surfaces for the South, North and East exits have been scheduled for a contracted company to repair. The exits will be free from cracks, pitting and uneven surfaces by 04/16/15. All residents have the potential to be affected. If a crack or uneven surface is discovered maintenance will be notified for repair immediately. Maintenance	04/16/2015

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K 051 SS=C Bldg. 01	<p>requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 20 or more residents on the North, South, and East smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 03/17/15 between 11:15 a.m. and 2:00 p.m., the concrete exit discharge surfaces for the South, North and East exits were cracked across the width of the path, damaged by pitting and shifting of the pads making them an uneven walking surface. The Maintenance Director acknowledged at the time of observation, the surfaces were not in good condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path</p>		<p>will conduct routine preventative maintenance monitoring of the condition of the concrete surfaces monthly during routine preventative maintenance rounds. Review through Quality Assurance committee will be conducted monthly through the next quarter. If no discrepancies noted the facility will follow the regular Quality Assurance schedule. Completion date: April 16, 2015.</p>		

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	<p>of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm systems components and devices, such as, smoke detectors, heat sensors and fire alarm pull stations was completed accurately. NFPA 72, 7-3.2 requires fire alarm system devices, such as, smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the facility's fire alarm system Inspection and Testing Form dated 05/21/14 with the Administrator and Maintenance Director on 03/17/15 at 2:25 p.m., the Alarm-Initiating Devices and Circuit Information listed "9 Manual Fire Alarm Boxes, 39 Photo Detectors, and 142 Heat</p>	K 051	<p>The facility's contracted fire alarm system company was notified of the conflicting information in regards to the number of pull stations, smoke detectors and heat detector's listed on the Alarm-Initiating Devices and Circuit Information and Equipment Lists. The contracted company has corrected the information and provided the facility with the corrected list. All residents have the potential to be affected. Maintenance will conduct routine preventative maintenance monitoring of the information provided on the list for accuracy monthly. Any further inaccuracies will be reported and corrected immediately. Review through the Quality Assurance committee will be conducted monthly through the next quarter. If no discrepancies are noted, the regularly scheduled Quality Assurance process will be followed. Completion Date: March 18, 2015</p>	03/18/2015

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K 064 SS=E Bldg. 01	<p>Detectors". Another page for the report dated 05/21/14 from the same fire inspection contractor was titled Fire Alarm Report and included an "Equipment List" which listed as noted," Pull Stations 10, Smoke Detectors 36, and Heat Detectors 137". The device list for the function test of each of these devices tested on 05/21/14 included the testing for the number of devices on the Equipment List. The Administrator and Maintenance Director said at the time of record review, they did not know why one page of the same report had different numbers of devices listed. They did not know how many of each device was in the facility and whether devices had been added, removed or not tested.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure annual and monthly checks were provided for a portable fire extinguisher in 1 of 5 smoke compartments. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires that extinguishers shall be</p>	K 064	1. The facility's contracted fire alarm service company was notified of the fire extinguisher located in the exit corridor near the social services office of an inspection tag with the last annual service listed as January 2014, the lack of documented monthly checks on the tag for the fire	03/18/2015

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	<p>subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance that extinguisher will operate effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect visitors, staff and 10 or more residents in the West smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 03/17/15 at 2:00 p.m., a fire extinguisher in the exit corridor near the social services office had a service and inspection tag which identified the last annual service had been conducted in January 2014. No monthly checks were documented on the tag for the fire extinguisher. The paint was peeling from the bottom of the cylinder and rust was evident. The Administrator acknowledged at the time of observation, reliable operation of the fire extinguisher</p>		<p>extinguisher and the condition of the extinguishers paint peeling and noted rust. All residents have the potential to be affected. The contracted company had ordered a replacement for the temporary fire extinguisher it had left upon its February inspection of the facility's fire extinguishers in February. The aforementioned extinguisher was immediately removed from service on 3/17/15 and replaced with another extinguisher that meets regulation requirements. Maintenance will conduct routine preventative maintenance inspection and monitoring of the fire extinguishers and complete a thorough check of each extinguisher and log inspection dates on the inspection tag monthly. Any problems noted will be immediately corrected. Review through the Quality Assurance program will continue monthly for the next quarter. If no discrepancies Quality Assurance will follow the regular scheduled Quality Assurance process. Completion Date: March 18, 2015. 2. The fire extinguisher located on the floor of the physical therapy room was immediately securely placed on a shelf on 03/17/15. The contracted fire alarm system company was notified and a bracket was ordered to hang the extinguisher. The bracket was installed by the maintenance director on 3/18/15. All residents</p>	

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	<p>was not assured.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a portable fire extinguisher in 1 of 5 smoke compartments was installed on a hanger, bracket, mounted in a cabinet or set on a shelf. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1-6.6 requires that extinguishers shall be installed on the hangers or in the brackets supplied, mounted in cabinets or set on shelves. NFPA 10 1-6.7 requires extinguishers installed under conditions where they are subject to dislodgement shall be installed in brackets specifically designed to cope with this problem. This deficient practice could affect visitors, staff and 10 or more residents in the West smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 03/17/15 at 11:30 a.m., a fire extinguisher was located on the floor of the physical therapy room. The Maintenance Director acknowledged at the time of observation, reliable operation of the fire extinguisher was not assured.</p>		<p>have the potential to be affected. Maintenance will continue routine preventative maintenance monitoring of fire extinguishers for proper placement monthly. Any problems noted will be corrected or repaired as needed. Review through the Quality Assurance program will be conducted monthly for the next quarter. If no discrepancies are noted, facility will follow the regular Quality Assurance schedule process. Completion Date: March 18, 2015.</p>				

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K 144 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on interview and record review, the facility failed to ensure the offsite fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <p>a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas</p> <p>Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with</p>	K 144	The natural gas provider was immediately contacted on 03/17/15 for a copy of the letter of reliability of fuel supply. The signed letter from the provider was received by the facility on 03/19/15. All residents have the potential to affected. The maintenance director will conduct routine preventative maintenance monitoring monthly of the generator maintenance and testing record which will include acknowledging the letter of reliability located in the preventive maintenance records. Review through the Quality Assurance committee will be conducted monthly for the next quarter. If no discrepancies are noted Quality Assurance will follow the regular schedule process. Completion Date: March 19, 2015.	03/19/2015			

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	<p>the provision for automatic transfer from the primary energy source to the alternate energy source.</p> <p>CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery.</li> <li>2. A brief description that supports the statement regarding the reliability.</li> <li>3. A statement that there is a low probability of interruption of the natural gas.</li> <li>4. A brief description that supports the statement regarding the low probability of interruption,</li> <li>5. The signature of a technical person from the natural gas provider.</li> </ol> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation and interview with the Administrator and Maintenance Director on 03/17/15 at 1:05 p.m., the emergency generator was run on natural gas without a liquid fuel backup. On 03/17/15 at 2:20 p.m., a review of the generator maintenance and testing records did not include a letter from their natural gas supplier giving notice the gas</p>			

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K 147 SS=E Bldg. 01	<p>supply to the generator had a low probability of an interruption of service. The Administrator confirmed at the time of observation a letter or other evidence could not be found.</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 Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 3 of 5 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, 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 visitors, staff, and 10 or more residents in the East, South and Center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director on 03/17/15 between 11:30 a.m. and 1:30 p.m., a blow dryer was plugged into a</p>	K 147	<p>The blow dryer plugged into the power strip located in the beauty shop was immediately unplugged on 03/17/15. The power strips in room 310 and 317 located near the residents beds were immediately relocated on 03/17/15. The refrigerator plugged into a power strip in room 208 was immediately unplugged on 03/17/15. A complete facility audit was immediately preformed on 03/17/15 for improper utilization of</p>	04/16/2015

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	<p>power strip in the beauty shop. Power strips were located under and adjacent to resident beds in rooms 310 and 317. In room 208 a refrigerator was plugged into a power strip. The Administrator acknowledged at the time of observations, the power strips were in use.</p> <p>3.1-19(b)</p>		<p>power strips. No further improper use was noted. All residents have the potential to be affected. Maintenance will continue to conduct preventative maintenance monitoring of each resident room for the use of power strips weekly. Any power strips found to be used improperly will be immediately corrected and/or removed. Review through Quality Assurance will be completed monthly through the next quarter. If no discrepancies noted then will follow regular scheduled Quality Assurance process. Completion Date: March 18, 2015.</p>	