STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155191		07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER HEALTH CARE CENTER	2210 GREENTREE N CLARKSVILLE, IN 47129

(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 0000 Bldg. 01	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). Survey Date: 07/16/15 Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130 At this Life Safety Code survey, Westminster 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. There is no fire separation between the original building and the new Rehabilitation Gym because the original building and Rehabilitation Gym are of the same	K 0000	K000- Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law. To ensure the facility meets these requirements the following measure will be taken by: August 15, 2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	construction type. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 42 in the healthcare portion of the facility at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.			
K 0011 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 Based on observation and interview, the facility failed to ensure the two hour fire rated separation wall between the health care center and the residential living apartments was provided with a 1 1/2 hour fire rated door. LSC 19.1.1.4.2 refers to Section 8.2. Section 8.2.3.2.3.1 requires every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the	K 0011	K011- Maintenance or designee will remove paint off of the doors in the east end of the long hall so that the fire rating label is clearly visible. Door hardware will also be replaced. These repairs will be completed by August 15, 2015. To continue to make sure this deficiency does not reoccur maintenance will complete an audit to ensure all smoke barrier doors have fire rating labels that are clearly visible. The smoke barrier	08/15/2015

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129	

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	other. The fire protection rating for opening protective's shall be as follows (1) 2-hour fire barrier - 1 1/2 hour fire protection rating. This deficient practice could affect all healthcare residents in the event of a fire in the fire barrier located between the healthcare portion of the facility and the residential portion of the facility. Findings include: Based on observation on 07/16/15 at 10:50 a.m. with the maintenance supervisor, the maintenance supervisor identified the wall at the east end of the Long Hall as a two hour fire barrier separation wall between the health care center and the residential apartments. Furthermore, the set of doors in the two hour fire wall had fire labels which were scratched and the fire rating of the doors could not be determined. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)		door label audit will be completed by August 15, 2015 and monitored every quarter. All audits will be discussed at the monthly Quality Assurance meeting and filed in the maintenance log binder for further review.	
K 0015 SS=A Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or			

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	movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2			
	Based on observation and interview, the facility failed to ensure 1 of 3 mechanical rooms was provided with an interior finish with a flame spread rating of Class A, Class B or Class C. This deficient practice affect maintenance staff who use the healthcare mechanical room. Findings include: Based on observation on 07/16/15 at 12:20 p.m. with the maintenance supervisor, the healthcare mechanical room south wall had a two foot by four foot section of drywall missing. Based on an interview with the maintenance supervisor on 07/16/15 at 12:30 p.m., the drywall was cut out to repair a water pipe six months ago and has not been repaired. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)	K 0015	K 015- To ensure the facility meets compliance standards with NFPA Life Safety Code Standard, Maintenance Director or designee will replace the missing drywall piece in the Health Care Center. To ensure this deficiency does not effect any residents, visitors, or staff Maintenance Director or designee will complete a monthly audit to assure any compromised drywall is repaired immediately. Findings will be recorded and discussed at month Quality Assurance meeting. This audit will be completed by August 15, 2015.	08/15/2015
K 0025	NFPA 101			

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SS=E Bldg. 01	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			
	Based on observation and interview, the facility failed to ensure the smoke barriers in 2 of 7 healthcare attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affect 16 residents who reside on the Walnut Grove Hall and 12 residents who reside on the Peach Tree Hall. Findings include: Based on observations with the maintenance supervisor on 07/16/15 from	K 0025	K025- Maintenance Director or designee will seal open electrical penetrations through the attic smoke barriers with a fire rated caulk in both Walnut Grove and Peach Tree corridors. This repair will be completed by August 15, 2015. Maintenance Director or designee will conduct an audit of all smoke barrier walls to ensure the protection of all residents, visitors, and staff from these deficiencies. This audit will be completed by August 15, 2015 by Maintenance Director or designee. To continue to ensure the safety of residents, visitors, and staff, Maintenance Director or designee will record a log of an audit every quarter to ensure that any further penetrations will be sealed with a fire rated sealant immediately so that the facility remains in compliance with NFPA 101 Life Safety Code Standard. The Maintenance Director or designee will review audits at monthly Quality	08/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 07/16/2015

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	12:25 p.m. to 1:00 p.m., the following attic smoke barrier walls had penetrations not firestopped; 1. The Walnut Grove Hall attic smoke barrier wall had two, two inch open electrical wiring conduits on both sides of the smoke barrier wall with no fire stopping material used to seal the openings. 2. The Peach Tree Hall attic smoke barrier wall had two, two inch open electrical wiring conduits on both sides of the smoke barrier wall with no stopping material used to seal the openings. The Walnut Grove Hall and Peach Tree Hall attic smoke barrier open electrical conduits not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)		Assurance meetings.	
K 0029 SS=B Bldg. 01	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			

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	inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 2 of 3 hazardous areas, such as a fuel fire equipment rooms, and a laundry room over 100 square feet, were provided with self closing devices which would cause the doors to automatically close and latch into the door frame and provided with smoke resistant doors. This deficient practice affects laundry staff and maintenance staff. Findings include: Based on observations on 07/16/15 during a tour of the natural gas boiler and laundry room with the maintenance supervisor from 9:45 a.m. to 10:20 a.m., the west laundry room corridor door had a two inch gap along the latching side of the door in the closed position and failed to latch into the door frame. Furthermore, the natural gas boiler room door lacked a self closing device. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)	K 0029	K029- 1. Maintenance Director or designee will replace the west corridor laundry door and hardware to eliminate current gap. Maintenance Director or Designee will also install a new self closing Device to ensure the new door latches seals gap correctly. Repairs to be completed by August 15, 2015. Maintenance Director or Designee will monitor and test door on a weekly basis to ensure that door continues to work properly. Maintenance Director or designee will record and repair deficiencies immediately if necessary to ensure the safety of laundry and maintenance personnel. 2. Maintenance Director or designee will install a new self closing device to the natural gas boiler room door. This repair will be completed by August 15, 2015. Maintenance Director or designee will monitor and test door on a weekly basis to ensure the door continues to work properly. Maintenance Director or designee will record and repair deficiencies immediately if necessary to ensure the safety of all individuals in case of emergency. Maintenance Director or designee will report results of weekly audits at monthly Quality Assurance meeting.	08/15/2015
K 0046	NFPA 101			

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	155191		07/16/2015

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SS=F Bldg. 01	LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation, record review and interview; the facility failed to ensure 12 of 12 battery backup lights in the health care center were tested annually for 90 minutes over the past year to ensure the lights would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the event of battery backup light failure during periods of power outages. Findings include: Based on record review on 07/16/15 at 9:45 a.m. with the maintenance supervisor, the Emergency Lighting	K 0046	K046- Maintenance Director or designee will provide the copy of documents showing the evidence that the facility is in compliance with the NFPA 101 Life Safety Code Standard 19.2.9.1. Due to recent position changes maintenance was unable to locate these documents at the time of the Life Safety Code Survey that was conducted on July 16, 2015. Maintenance Director or Designee will conduct a 90 minute test on all emergency lights and will record results in the emergency lighting log and file in the appropriate audit binder and keep on file for future review. This will be completed by August 15, 2015. Test results will be discussed at the monthly Quality Assurance meeting.	08/15/2015

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	Healthcare Log was reviewed and indicated a monthly test of the battery backup lights were conducted over the past year but lacked an annual ninety minute test. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)			
K 0052 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on record review and interview, the facility failed to ensure 77 of 77 smoke detectors in the health care center were tested for sensitivity every two years in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be	K 0052	K 052- Maintenance Director or designee will provide the copy of documents showing the evidence that the facility is in compliance with the NFPA 72, National Fire Alarm Code. Due to recent position changes maintenance was unable to locate these documents at the time of the Life Safety Code Survey that was conduction on July 16, 2015. Maintenance Director or designee will schedule with the appropriate vendor to conduct a sensitivity and calibration test to 77 of 77 smoke detectors located throughout the health care center. This will be completed by August 15, 2015. Maintenance	08/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It		Director or designee will record the results into the appropriate audit binder and keep on file for future review. The sensitivity test will be completed on or before August 15, 2015. Test results will be discussed at the Quality Assurance meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155191		07/16/2015

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	shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. This deficient practice affects all residents, staff and all visitors in the facility. Findings include: Based on record review on 07/16/15 at 9:00 a.m. with the maintenance supervisor, the most recent Sensitivity Test Report for eighty one health care center smoke detectors from Dalmation Inc. was dated 04/09/12, which was a period exceeding two years. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)			
K 0062 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in	K 0062	K062- Maintenance Director or designee will schedule for the replacement of corroded sprinkler head found during the Life Safety	08/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
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	corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 12 residents who use the outside smokers shack. Findings include: Based on observation on 07/16/15 at 11:50 a.m. with the maintenance supervisor, the outside smokers shack exit overhang sprinkler was completely covered in green corrosion. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)		Code Survey conducted on July 16, 2015 by appropriate vender. This repair will be completed by August 15, 2015. Maintenance Director or designee will conduct a complete facility audit of all sprinkler heads in the Health Care Center to ensure all sprinkler heads are free from paint, dust, and corrosion. Audit will be completed by maintenance department before August 15, 2015. Documents will be filed in the maintenance log binder to ensure the fire sprinkler system is in compliance with NFPA 25, 1998 edition 2-2.1.1. Furthermore, Maintenance Director or designee will conduct this audit quarterly and discuss findings at monthly Quality Assurance meeting.	
K 0143 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (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;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129	

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	(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (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 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with a 45 minute fire rated door. This deficient practice could affect 9 residents who reside on Honeysuckle Lane Hall. Findings include: Based on observation with the maintenance supervisor on 07/16/15 at 12:20 p.m., the Honeysuckle Lane Hall liquid oxygen storage room, where six full liquid oxygen containers were stored, had a door with a fire resistance label scratched and the fire rating of the door could not be determined. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)	K 0143	K 143- Maintenance Director or designee will replace the door leading to the oxygen room located on Honey Suckle Lane with a new fire rated approved door with legible fire rating label. This repair will be completed by August 15, 2015. To continue to ensure the safety of the residents, visitors, and staff, Maintenance Director or designee will add this door to the weekly smoke barrier door check list and monitor weekly for correct operation of the doors closure, latch, and seal. Maintenance Director or designee will also audit to ensure all smoke barrier doors display appropriate fire rating tag. Findings will be discussed at the monthly Quality Assurance meeting.	08/15/2015
K 0154 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler			

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WESTMINSTER HEALTH CARE CENTER	2210 GREENTREE N CLARKSVILLE, IN 47129

(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
	system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, standard for Inspection, Testing and maintenance of water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all residents in the health care	K 0154	K154- To ensure the facility meets compliance standards the following measures will be taken. A policy and procedure will be put in place regarding the correct actions that need to be taken in case of an emergency event where the automatic sprinkler system has to be out of service for four or more hours in a 24 hour period. To ensure this deficiency does not reoccur the facility staff will be in serviced on the policy and procedure by August 15, 2015. This will be added to the annual in service list for all employees and new employees will be orientated at employee orientation. Documentation of in service will be filed in the Fire Disaster Plan binder.	08/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
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	portion of the facility. Findings include: Based on a review of the Fire Disaster Plan on 07/16/15 at 9:15 a.m. with the maintenance supervisor, the written plan lacked a policy in the event the automatic sprinkler system had to be placed out of service for four hours or more in a twenty four hour period. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)			
K 0155 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC,	K 0155	K 155- To ensure the facility meets compliance standards the following measures will be taken. A policy and procedure will be put in place regarding the correct actions that need to be taken in case of and emergency event where the fire alarm system has to be out of service for four or	08/15/2015

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	Section 9.6.1.8 to protect 42 of 42 residents. This deficient practice could affect all residents in the health care portion of the facility. Findings include: Based on a review of the Fire Disaster Plan on 07/16/15 at 9:15 a.m. with the maintenance supervisor, the written plan lacked a policy in the event the fire alarm system had to be placed out of service for four hours or more in a twenty four hour period. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)		more hours in a 24 hour period. To ensure this deficiency does not reoccur the facility staff will be in serviced on the policy and procedure by August 15, 2015. This will be added to the annual in service list for all employees. New employees will be orientated at employee orientation. Documentation of in service will be filed in the Fire Disaster Plan binder.	
K 0000 Bldg. 02	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). Survey Date: 07/16/15 Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130	K 0000	K000- Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law. To ensure the facility	

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	At this Life Safety Code survey, Westminster 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) and 410 IAC 16.2. The 2009 Rehabilitation Gym was surveyed with Chapter 18, New Health Care Occupancies. This 2009 addition to the one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 94 and had a census of 42 in the healthcare portion of the facility at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.		meets these requirements the following measure will be taken by: August 15, 2015.	
K 0052 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD 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			

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	complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure 4 of 4 smoke detectors in the rehabilitation gym were tested for sensitivity every two years in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes	K 0052	K 052- Maintenance Director or designee will provide the copy of documents showing the evidence that the facility is in compliance with the NFPA 72, National Fire Alarm Code. Due to recent position changes maintenance was unable to locate these documents at the time of the Life Safety Code Survey that was conduction on July 16, 2015. Maintenance Director or designee will schedule with the appropriate vendor to conduct a sensitivity and calibration test to 77 of 77 smoke detectors located throughout the health care center. This will be completed by August 15, 2015. Maintenance Director or designee will record the results into the appropriate audit binder and keep on file for future review. The sensitivity test will be completed on or before August 15, 2015. Test results will be discussed at the Quality Assurance meeting.	08/15/2015

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	a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. This deficient practice affects 12 residents who use the rehabilitation gym. Findings include: Based on record review on 07/16/15 at 9:00 a.m. with the maintenance supervisor, the most recent Sensitivity Test Report for eighty one health care center smoke detectors from Dalmation Inc. was dated 04/09/12, which was a period exceeding two years. This was			

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	verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)			
K 0154 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, standard for Inspection, Testing and maintenance of water-Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier,	K 0154	K154- To ensure the facility meets compliance standards the following measures will be taken. A policy and procedure will be put in place regarding the correct actions that need to be taken in case of an emergency event where the automatic sprinkler system has to be out of service for four or more hours in a 24 hour period. To ensure this deficiency does not reoccur the facility staff will be in serviced on the policy and procedure by August 15, 2015. This will be added to the annual in service list for all employees and new employees will be orientated at employee orientation. Documentation of in service will be filed in the Fire Disaster Plan binder.	08/15/2015

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	alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect 12 residents who use the rehabilitation gym. Findings include: Based on a review of the Fire Disaster Plan on 07/16/15 at 9:15 a.m. with the maintenance supervisor, the written plan lacked a policy in the event the automatic sprinkler system had to be placed out of service for four hours or more in a twenty four hour period. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)			
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	service. 9.6.1.8 Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 to protect 42 of 42 residents. This deficient practice could affects 12 residents who use the rehabilitation gym. Findings include: Based on a review of the Fire Disaster Plan on 07/16/15 at 9:15 a.m. with the maintenance supervisor, the written plan lacked a policy in the event the fire alarm system had to be placed out of service for four hours or more in a twenty four hour period. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 07/16/15 at 1:30 p.m. 3.1-19(b)	K 0155	K 155- To ensure the facility meets compliance standards the following measures will be taken. A policy and procedure will be put in place regarding the correct actions that need to be taken in case of and emergency event where the fire alarm system has to be out of service for four or more hours in a 24 hour period. To ensure this deficiency does not reoccur the facility staff will be in serviced on the policy and procedure by August 15, 2015. This will be added to the annual in service list for all employees. New employees will be orientated at employee orientation. Documentation of in service will be filed in the Fire Disaster Plan binder.	08/15/2015