STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER WESLEY MANOR HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 N MAIN ST FRANKFORT, IN 46041	

(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
K010000	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: 07/23/13 Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Wesley Manor Health 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 E wing ground floor of an original building where the physical therapy department is located was surveyed with Chapter 19, Existing Health Care Occupancies . The physical therapy department was located on E wing on the ground floor of a four story unsprinklered building with a basement determined to be Type II (222).	K010000	Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor Health Center provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction:	

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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	The E wing has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 96 and had a census of 79 at the time of this survey. All areas where the residents have customary access were sprinklered except those cited at K-999. All areas providing facility services located in adjacent buildings, including the maintenance support services were unsprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/26/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010062 SS=F	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 ensure 2 of 2 private fire hydrants serving the health care center were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all staff, visitors and residents. Findings include: Based on observation and interview with the director of facility services on 07/23/13 between 12:30 p.m. and 3:30 p.m., there were two private fire hydrants for the health care center on the facility's property. The last documented inspection of the hydrants by the facility's service contractor was dated 07/27/12. The director of facility services said at the time of record, there were no other	K010062	This tag was cited due to 2 facility fire hydrants not having an annual inspection more recently than 7/27/12. The facility's survey was conducted on 7/23/13, which is less than one year from the prior inspection. However, the facility will address the tag as follows. The facility's vendor for inspecting our fire hydrants will be scheduled to complete this year's inspection. In order to prevent this from happening in the future, the vendor will be requested to schedule the next annual inspection whenever an inspection is completed. Facility Services keeps a record of all scheduled inspections and their expected frequencies, along with the results of the most recent inspections, in a Life Safety log book in the Facility Services Department. This log will include hydrant inspections, their results, and the scheduled date of the next inspection. A quality assurance assessment to make certain this log is being maintained, and that all other required inspections are timely, will be conducted quarterly by the	08/22/2013

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	records of a more current hydrant inspection. 3.1-19(b)		Facility Services Manager and results will be reported to the facility's quality assurance committee. This will address this concern for all residents who had the potential to be impacted by this problem. All corrections for this tag will be completed by August 22, 2013	

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K019999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 3 wings customarily used by residents. This deficient practice affects visitors, staff, and 10 or more residents in the ground floor E building. Findings include:.	K019999	This tag/state finding was cited due to the facility's Therapy Department being located in the residentially licensed area of the facility which is not sprinklered. In order to correct this problem, the facility is relocating its Therapy Department to an area of the facility where sprinkler systems exist throughout. There are no other needs for the facility's comprehensive or skilled residents to access the E-wing of the facility for services. All services customarily provided to residents of the skilled and comprehensive care facility can be accessed directly within that portion of the facility. This will correct the potential problem for all residents who had the potential to be impacted by the lack of sprinkler coverage within the Therapy area and corridors which led to it. The facility is requesting an extension with regard to the completion of these corrections due to the need for contracted services to complete minor construction. In order to move the Therapy Department, 3 other service areas will have to be relocated as well. All of these areas will also require some minor construction to take place. We are not able to complete this work within 30 days of the date of the survey, however, we are certain that we can complete this work in less than 90 days from	10/20/2013

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	Based on observation with the director of facility services on 07/23/13 at 3:30 p.m., sprinkler protection was not provided for the ground floor of E building housing the physical therapy department and the corridor access from F building. The director of facility services acknowledged at the time of observation, the areas were not protected by sprinklers. 3.1-19(ff)		the date of the Survey. During the construction period prior to the moves, the facility will provide additional fire extinguishers in the therapy department, and in the corridors leading to it. The facility respectfully requests and extension of the due date for correction of this tag. Our proposed date for the required corrections is October 20, 2013.	

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WESLEY MANOR HEALTH CENTER	1555 N MAIN ST FRANKFORT, IN 46041

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K020000	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: 07/23/13 Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Wesley Manor Health 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 18, New Health Care Occupancies and 410 IAC 16.2. Most of the facility was surveyed under Chapter 18, New Health Care Occupancies due to the gutting and renovation of the health care wing located in the original building identified as F, and the addition of two new wings, G and H, in 2005. This facility was surveyed as three	K020000	Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor Health Center provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents. As required, the facility submits the following plan of correction:	

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	buildings due to different construction types and construction and renovation dates. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement, was determined to be Type II (222). G and H wings were one story, sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors and in resident rooms. The facility has the capacity for 96 and had a census of 79 at the time of this survey. All areas where the residents have customary access were sprinklered except those cited at K 56. All areas providing facility services located in adjacent buildings, including the maintenance support services were unsprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K020056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and record review, the facility failed to ensure 2 of 2 elevators were provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect 42 resident who reside on the first floor. Findings include: Based on observations with the director of	K020056	This tag was cited due to 2 elevators not being equipped with sprinkler coverage. This problem will be corrected by the facility working with the elevator service company to install the necessary sprinkler equipment and shunt-trip mechanisms for elevators #4 and #5. This will correct the issue for all residents who would potentially be impacted by this problem. The new equipment will be inspected on the same schedule as our existing sprinkler system. The facility has applied for an extension/waiver due to not being able to have this project completed by August 22, 2013. At the time of submission of this plan, 3 separate contractors have met, who will have to work together on this project (The elevator contractor, electricians, and the contractor who services	11/23/2013

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	facility services on 7/23/13 between 11:30 a.m. and 4:00 p.m., elevators 4 and 5 were not provided with sprinkler coverage. This was verified by the director of facility services at the time of record review on 07/23/13 at 3:45 p.m. 3.1-19(b)		our fire alarms and supression systems). They are currently working on the plans for the project and securing a quote. Because the three contractors must work together on this issue, there are obvious scheduling delays. In order to reduce the risks to residents during this period, we will place fire extinguishers in the elevators. We respectfully requst that we be granted an, extension which will allow for corrections for this tag to be completed by 11/23/13.	

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K020064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the G wing first floor service kitchen in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect 4 or more staff, visitors and and any residents using the corridor located adjacent to the kitchen. Findings include: Based on observation with the director of	K020064	This tag was cited due to a K-class fire extinguisher in one kitchen not having signage to indicate that it is to be used for class K fire suppression only. This kitchen in question is a distribution/service kitchen only. There is no cooking performed in this kitchen that would use vegetable/animal oils or fats. Therefore, there is no requirement to have a K-Class fire extinguisher in this kitchen. To correct this problem, the K-Class extinguisher has been removed. This will correct the problem for all residents who would potentially be impacted by this problem. All maintenance and kitchen staff will receive additional education to remind them of requirements regarding K-class fire protection. All corrections for this tag will be completed by August 22, 2013.	08/22/2013

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	facility services on 07/23/13 at 11:50 a.m., the first floor G wing service kitchen was equipped with a K-class extinguisher and no placard was posted near the K-class fire extinguisher. At the time of observation, the director of facility services acknowledged there was no placard. 3.1-19(b)			