

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | X3) DATE SURVEY COMPLETED 05/11/2016 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 | <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: 05/11/16</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>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.</p> <p>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</p> | K 0000 | | |
|------------------------|--|--------|--|--|

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.

| | | | |
|--|---|--|---|
| 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 05/11/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0025 SS=E Bldg. 01 | <p>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 68 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 05/16/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observations and interview, the facility failed to ensure the smoke barriers in 4 of 6 attic smoke barriers in the health care center were constructed to provide at least a one half hour fire</p> | K 0025 | (a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? All residents can be affected by the deficient practice. Foam will be replaced with flame-retardant | 06/10/2016 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | X3) DATE SURVEY COMPLETED 05/11/2016 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 |
|--------------------|---|---------------|--|----------------------|
| | <p>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 affects 14 residents who reside on the 200 Skilled Hall, 12 residents who reside on the Long Skilled Hall, 42 residents who use the main dining room, and 10 residents who reside on the ICF Short Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 05/11/16 from 12:25 p.m. to 1:00 p.m., the following attic smoke barrier walls had penetrations not fire stopped;</p> <ol style="list-style-type: none"> The 200 Skilled Hall attic smoke barrier wall had a one half inch gap around a cable bundle not fire stopped, a two inch gap around a fire damper duct penetration not fire stopped, and a two inch gap around a water pipe penetration not fire stopped. The Long Skilled Hall attic smoke barrier wall had a one half inch gap around a fire damper duct penetration not | | <p>caulking in smoke barrier walls.</p> <p>(b) How you will identify other residents having the potential to be affected by same deficient practice and what corrective actions will be taken. All smoke barriers walls will be audited monthly by maintenance staff assigned on a monthly basis to ensure that they are in compliance. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The maintenance staff will be re-educated on checking smoke barrier walls on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of Maintenance or designee will audit smoke barrier walls on a monthly basis. Any maintenance team member who does not report smoke barrier wall concerns will be re-educated and counseled as necessary with the progressive disciplinary process.</p> <p>(d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit smoke barrier walls for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed</p> | |

| | | | | | |
|--|---|---|---|----------------------|---|
| 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 05/11/2016 |
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0029 SS=B Bldg. 01 | <p>fire stopped.</p> <p>3. The Dining Hall attic smoke barrier wall had three, two inch gaps filled with yellow expandable foam and a one inch gap around a cable bundle penetration not fire stopped.</p> <p>Based on an interview with the maintenance director at the time of observation, the expandable foam is not a fire stopping product with a flame spread rating and the facility does not have any documentation of the fire resistance rating of the expandable foam.</p> <p>4. The ICF Hall near the Dining Hall attic smoke barrier wall had two, three inch gaps around cable bundles not fire stopped.</p> <p>The 200 Skilled Hall, the Long Skilled Hall, the Dining Hall, and the ICF Hall attic smoke barrier gaps not fire stopped was verified by the maintenance director at the time of observations and acknowledged at the exit conference on 05/11/16 at 1:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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</p> | | monthly and submitted to QAPI for a period of one year. | | |

| | | | |
|--|---|--|---|
| 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 05/11/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 |
|--------------------|---|---------------|---|----------------------|
| | <p>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 observations and interview, the facility failed to ensure 1 of 13 corridor doors to combustible storage rooms over 50 square feet in the health care center mechanical room Service Hall was provided with self-closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect all staff who work in the health care center mechanical room Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 10:30 a.m. with the maintenance director, the health care center mechanical room Service Hall medical records room, which measured ninety square feet and stored twenty two cardboard boxes of paper medical records, lacked a self-closing device on the door. This was verified by the maintenance director at the time of observation and acknowledged at the exit conference on 05/11/16 at 1:15 p.m.</p> <p>3.1-19(b)</p> | K 0029 | <p>(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? All residents can be affected by the deficient practice. Replacing hinges to self-closing hinges on the medical storage room door.</p> <p>(b) How you will identify other residents having the potential to be affected by same deficient practice and what corrective actions will be taken. Medical storage room will be monitored on a monthly basis to ensure that medical room door closes securely to ensure that they are in compliance. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The deficient practice will not recur after the medical records door hinges have been replaced with the self closing hinges. Maintenance staff will be re-educated on checking door closures on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of Maintenance or designee will audit door closure on a monthly basis. Any maintenance team member who does not report Medical Storage Room Door</p> | 06/10/2016 |

| 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 05/11/2016 |
|--|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0044 SS=E Bldg. 01 | <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets on the health care center was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self-closing or automatic closing in accordance with 7.2.1.8. In addition, NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 42</p> | K 0044 | <p>concerns will be re-educated and counseled as necessary with the with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit medical room door closure for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year</p> <p>(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? All residents can be affected by the deficient practice. Replacing Fire doors (b) how you will identify other residents having the potential to be affected by same deficient practice and what corrective actions will be taken. Fire Doors will be monitored on a monthly basis to ensure that fire door closes securely to ensure that they are in compliance. (c) What measures will be put into place or what systematic changes you will make to ensure that the</p> | 06/10/2016 | |

| | | | | | |
|--|--|---|--|----------------------|---|
| 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 05/11/2016 |
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0062 SS=F Bldg. 01 | <p>residents who use the Main Dining Hall and could use the healthcare center to the residential center fire door set as a secondary exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 11:10 a.m. with the maintenance director, the fire door set of doors located at the two hour fire wall between the health care center and the residential center had a two inch gap in the closed position. Furthermore, the magnetic hold down device installed at the top of the door prevented the fire doors to latch on two separate attempts. This was verified by the maintenance director at the time of observation and acknowledged at the exit conference on 05/11/16 at 1:15 p.m.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 sprinkler system gauges were either replaced or</p> | K 0062 | <p>deficient practices do not recur. The deficient practice will not recur after the Fire door has been replaced. Maintenance staff will be re-educated on checking door closures on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of Maintenance or designee will audit door closure on a monthly basis. Any maintenance team member who does not report fire door concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit fire door for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.</p> <p>(a) What corrective actions will be accomplished for the resident found to have been affected by</p> | 06/10/2016 | |

| | | | | | |
|--|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 05/11/2016 |
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 | |
| | <p>recalibrated every 5 years. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents in the health care center.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/11/16 at 9:30 a.m., one of two sprinkler system risers for the health care center, located in the basement maintenance workshop, had two water pressure gauges with a date of manufacture listed on the two gauges of 2008. Based on a review of A & A Fire Sprinkler Company Quarterly Sprinkler System Inspection Reports with the maintenance director on 05/11/16 a 9:15 a.m., the quarterly sprinkler system reports dating from 01/12/10 through 05/09/16 did not list the two maintenance workshop sprinkler riser water pressure gauges being replaced but did list the basement mechanical room sprinkler riser room four water pressure gauges being replaced in 2013. The lack of the basement maintenance workshop two sprinkler system water pressure gauges being replaced or recalibrated within five years was verified by the maintenance</p> | | <p>the deficient practice? All residents can be affected by the deficient practice. The sprinkler systems gauges will be replaced and monitored after replacement. (b) How you will identify other residents having the potential to be affected by same deficient practice and what corrective actions will be taken. Sprinkler system gauges will be monitored on a monthly basis to ensure that they are in compliance. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The deficient practice will not recur after the sprinkler systems gauges have been replaced. Maintenance staff will be re-educated on checking sprinkler system gauges on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of Maintenance or designee will audit sprinkler system gauges on a monthly basis. Any maintenance team member who does not report sprinkler system gauge concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit sprinkler system gauges for</p> | | |

| | | | |
|--|---|--|---|
| 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 05/11/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0067 SS=F Bldg. 01 | <p>director at the time of record review and acknowledged at the exit conference on 05/11/15 at 1:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> | K 0067 | <p>compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.</p> <p>(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? All residents can be affected by the deficient practice. The contractor agreement has been initiated to inspect the dampers. (b) How you will identify other residents having the potential to be affected by same deficient practice and what corrective actions will be taken. Fire Dampers will be monitored on a monthly basis to ensure that fire dampers function properly to ensure that they are in compliance. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The deficient practice will not recur after the Fire dampers have been inspected. Maintenance staff will be re-educated on checking fire dampers on a monthly basis. Any</p> | 06/10/2016 |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| 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 05/11/2016 | |
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0130 SS=F Bldg. 01 | <p>Findings include:</p> <p>Based on observations on 05/11/16 during a tour of the facility with the maintenance director from 9:10 a.m. to 1:00 p.m., the maintenance director verified the location of six fire dampers located in the smoke barrier walls in each smoke compartment corridor in the health care center. Based on an interview with the maintenance director on 05/11/16 at 10:10 a.m. during record review, the six fire dampers have not had a four year inspection conducted and no records were available for review. The lack of four year fire damper inspections on six fire dampers was acknowledged by the maintenance director at the exit conference on 05/11/16 at 1:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 48 of 48 health care center resident rooms for 6 of the past 12 months. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be</p> | K 0130 | <p>concerns from the monthly audits will be addressed in a timely manner. The Director of Maintenance or designee will audit fire dampers on a monthly basis. Any maintenance team member who does not report fire damper concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit fire dampers for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year.</p> <p>(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? All residents can be affected by the deficient practice. Smoke detectors will be inspected and documented on a monthly basis (b) how you will identify other residents having the potential to be affected by same deficient practice and what corrective</p> | 06/10/2016 | | | |

| | | | | | |
|--|--|---|---|----------------------|---|
| 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 05/11/2016 |
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0143 SS=E | <p>maintained. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 05/11/16 at 9:45 a.m. with the maintenance director, the Smoke Detector Weekly Test Report Log was reviewed and listed the forty eight resident room battery operated smoke detectors tested weekly over the past year until 10/29/15. Based on an interview with the maintenance director, it was indicated the maintenance worker in charge of the weekly resident room battery operated smoke detector tests resigned in November 2015 and the battery operated smoke detector tests have not been conducted since October 2015. The lack of resident room battery operated smoke detector monthly testing conducted since October 2015 was verified by the maintenance director at the time of record review and interview and acknowledged at the exit conference on 05/11/16 at 1:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> | | <p>actions will be taken. Smoke detectors will be monitored on a monthly basis to ensure that they are in compliance. (c) What measures you will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The deficient practice will not recur Maintenance staff will be re-educated on checking smoke detectors on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of Maintenance or designee will audit smoke detectors and documentation on a monthly basis. Any maintenance team member who does not report smoke detector or documentation concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit documentation for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year</p> | | |

| | | | |
|--|---|--|---|
| 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 05/11/2016 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 |
|--------------------|--|---------------|--|----------------------|
| Bldg. 01 | <p>Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</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; and</p> <p>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage room/transfer rooms was provided with a 45 minute fire rated door. This deficient practice could affect 34 residents who reside on the ICF Short Hall.</p> <p>Findings include:</p> <p>Based on observation on 05/11/16 at 12:15 p.m. with the maintenance director, the ICF Short Hall liquid oxygen storage room, which had six full liquid oxygen containers stored in the room, had a door with a twenty minute fire resistance label. Based on an interview with the ICF Short Hall charge nurse on 05/11/16 at 12:20</p> | K 0143 | <p>(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? Residents on the ICF short hall can be affected by the deficient practice. The Oxygen room doors will be replaced with a 45 minute rated door. (b) How you will identify other residents having the potential to be affected by same deficient practice and what corrective actions will be taken. Oxygen room door will be monitored on a monthly basis to ensure that they are in compliance. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The deficient practice will not recur</p> | 06/10/2016 |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____ | X3) DATE SURVEY COMPLETED 05/11/2016 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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. 02 | <p>p.m., the charge nurse indicated nursing staff transfers oxygen from the liquid oxygen containers into small portable containers for resident use. The lack of a forty five minute rated door on the ICF Short Hall liquid oxygen room was verified by the maintenance director at the time of observation and acknowledged at the exit conference on 05/11/16 at 1:15 p.m.</p> <p>3.1-19(b)</p> <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: 05/11/16</p> | K 0000 | <p>after the Oxygen room door has been replaced. Maintenance staff will be re-educated on checking Oxygen room door on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of Maintenance or designee will audit Oxygen Room door on a monthly basis. Any maintenance team member who does not report oxygen room door concerns will be re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit Oxygen room door for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year</p> | |

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____ | X3) DATE SURVEY COMPLETED 05/11/2016 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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 |
|--------------------|---|---------------|---|----------------------|
| | <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>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.</p> <p>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 68 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review on 05/16/16 - DA</p> | | | |

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191 | | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 05/11/2016 | |
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0062 SS=F Bldg. 02 | <p>NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 6 sprinkler system gauges were either replaced or recalibrated every 5 years. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects 12 residents who use the Rehabilitation Gym.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/11/16 at 9:30 a.m., one of two sprinkler system risers for the health care center, located in the basement maintenance workshop, had two water pressure gauges with a date of manufacture listed on the two gauges of 2008. Based on a review of A & A Fire Sprinkler Company Quarterly Sprinkler System Inspection Reports with the maintenance director on 05/11/16 a 9:15 a.m., the quarterly sprinkler system reports dating from 01/12/10 through</p> | K 0062 | <p>(a) What corrective actions will be accomplished for the resident found to have been affected by the deficient practice? All residents can be affected by the deficient practice. The sprinkler systems gauges will be replaced and monitored after replacement. (b) How you will identify other residents having the potential to be affected by same deficient practice and what corrective actions will be taken. Sprinkler system gauges will be monitored on a monthly basis to ensure that they are in compliance. (c) What measures will be put into place or what systematic changes you will make to ensure that the deficient practices do not recur. The deficient practice will not recur after the sprinkler systems gauges have been replaced. Maintenance staff will be re-educated on checking sprinkler system gauges on a monthly basis. Any concerns from the monthly check will be addressed in a timely manner. The Director of Maintenance or designee will audit sprinkler system gauges on a monthly basis. Any maintenance team member who does not report sprinkler system gauge concerns will be</p> | 06/10/2016 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____ | | X3) DATE SURVEY COMPLETED 05/11/2016 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 | |
| | 05/09/16 did not list the two maintenance workshop sprinkler riser water pressure gauges being replaced but did list the basement mechanical room sprinkler riser room four water pressure gauges being replaced in 2013. The lack of the basement maintenance workshop two sprinkler system water pressure gauges being replaced or recalibrated within five years was verified by the maintenance director at the time of record review and acknowledged at the exit conference on 05/11/15 at 1:15 p.m. 3.1-19(b) | | re-educated and counseled as necessary with the progressive disciplinary process. (d) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put in place. The Director of Maintenance or designee will audit sprinkler system gauges for compliance on a monthly basis. The findings will be reviewed by the Quality Assurance Performance Improvement committee (QAPI). These findings will be completed monthly and submitted to QAPI for a period of one year. | | |