

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  07/27/2016
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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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K 0000  Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/11/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>This survey was in conjunction with the PSR for the Comparative Federal Monitoring Survey conducted on 06/15/16.</p> <p>Survey Date: 07/27/16</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>At this PSR 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</p>	K 0000	<p>This plan of correction is prepared and executed because it is required by the provision of state and federal law. Westminster Health Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor are they of such character so as to limit its ability to renderadequate care. This plan of correction shall operate as Westminster Health Care Center credible allegation of compliance. This plan of correction is not meant to establish a standard of care, contract, obligation of position and Westminster Health Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0022 SS=E Bldg. 01	<p>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 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 81 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 07/29/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 health care center exits was provided with a</p>	K 0022	(A) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?	07/27/2016

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K 0025 SS=E Bldg. 01	<p>readily visible sign. This deficient practice affects 18 residents who reside on the ICF Hall and any residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observation on 07/27/16 during a tour of the facility with the maintenance director at 11:30 a.m., the ICF Hall exit near the fire barrier doors was not provided with a readily visible exit sign. Based on an interview with the maintenance director on 07/27/16 at the time of observation, the fire barrier doors were previously used as an exit for the ICF Hall and the facility changed the floor plan and fire evacuation plan to use the ICF Hall direct exit but did not install an illuminated exit light fixture above the exit door. The lack of a readily visible exit sign above the ICF Hall exit near the fire barrier doors was verified by the maintenance director at the time of observation and acknowledged by the administrator at the exit conference on 07/27/16 at 12:03 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire</p>		<p>The 18 residents have the potential to be affected by this deficiency. The exit sign was installed on the date of Survey (7/27/2016). (B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. Exit sign was installed on day of Survey 7/27/2016. (C) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All facility exits will be audited monthly by maintenance staff to assure proper signage. (D) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurances programs will be put into place. Exits will be audited monthly by maintenance staff and results of the audit will be communicated monthly to the QA committee by the Maintenance Director/designee. This deficiency was completed on date of survey 7/27/2016.</p>	

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	<p>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.</p> <p>8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 3 of 6 attic smoke barriers in the health care center 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 affects 19 residents who reside on the 200 Skilled Hall, 42 residents who use the main dining room, and 28 residents who reside on the ICF Short Hall.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director on 07/28/16 from 11:10 a.m. to 11:50 a.m., the following attic smoke barrier walls had penetrations not fire stopped;</p> <p>1. The 200 Skilled Hall attic smoke</p>	K 0025	<p>(A) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? All smoke barrier walls have been inspected and corrections made where necessary to ensure compliance by contractor Life Safety services. (B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected. All Smoke barrier walls have been inspected and repairs completed by noon 8/3/2016. (C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The facility will ensure that all exposed penetrations through the smoke barriers will be filled with an approved material. The Administrator/designee will monitor all Smoke barriers monthly as part of a preventative maintenance program. Any negative findings during monitoring will be corrected immediately. (D) Results of the Monitoring will be reviewed during the monthly Quality Assurance</p>	08/03/2016

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K 0029 SS=B Bldg. 01	<p>barrier wall near the nurses' station had a two inch gap around a fire damper duct penetration not fire stopped.</p> <p>2. The 200 Skilled Hall attic smoke barrier wall by resident room 210 had two, two inch gaps around electrical conduit penetrations and a two inch gap around a fire damper duct penetration not fire stopped.</p> <p>3. The Long ICF Skilled Hall attic smoke barrier wall had a one half inch gap around a fire damper duct penetration not fire stopped.</p> <p>The two 200 Skilled Hall attic smoke barrier wall gaps and the Long ICF Hall attic smoke barrier gaps not fire stopped was verified by the maintenance director at the time of observations and acknowledged by the administrator at the exit conference on 07/27/16 at 12:03 p.m.</p> <p>3.1-19(b)</p> <p>This deficiency was cited on 05/11/16. The facility failed to implement a systematic plan of correction to prevent recurrence.</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</p>		meeting for continued compliance, monitoring will be ongoing. The deficiency was corrected on 8/3/2016.				

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	<p>areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on 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 capable of resisting the passage of smoke and would self 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 07/27/16 at 11:40 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, failed to self close and latch into the door frame on two separate attempts and had a one inch gap where the door met the door frame. This was verified by the maintenance director at the time of observation and acknowledged by the administrator at the exit conference on 07/27/16 at 12:03 p.m.</p> <p>3.1-19(b)</p>	K 0029	<p>(A) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? There were no residents affected by the deficient practice. (B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The medical records storage room door hinges were adjusted on the day of Survey 7/27/2016 to allow proper closure and latching. The adjustments of the hinges also corrected the gap between the door and the door frame. (C) What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; all mechanical and medical records storage doors will be audited monthly by maintenance staff and any non-compliant doors will be addressed immediately. (D) How the corrective action will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance programs will be put into place: The maintenance Director/designee will audit all mechanical room doors and the Medical Records office storage doors monthly. The</p>	07/27/2016

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K 0044 SS=E Bldg. 01	<p>This deficiency was cited on 05/11/16. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <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 provided with a latching mechanism. 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 residents who use the Main Dining Hall and 18 residents who reside on the ICF Hall.</p> <p>Findings include:</p> <p>Based on observation on 07/27/16 at 11:30 a.m. with the maintenance director, the fire door set of doors located at the two hour fire wall between the health</p>	K 0044	<p>results will be reviewed at the monthly Quality Assurance meetings. This monitoring will be ongoing. This deficiency was corrected 7/27/2016.</p> <p>(A) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The newly installed fire door set of double doors has an automatic latching hardware added to the door on 7/29/2016. This door set is located between the Healthcare Center and the Residential Center. (B)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? The newly installed fire double door set had an automatic latching hardware added to the door on 7/26/2016. (C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; the Administrator or designee will monitor all doors requiring automatic latching hardware to ensure they are in place and are working properly on a monthly basis. Any negative findings during monitoring will be corrected immediately. (D) How the corrective action will be</p>	07/29/2016

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K 0067 SS=C Bldg. 01	<p>care center and the residential center was not provided with a latching mechanism on the south door, which had a magnetic releasing device installed on the top of the south door. This was verified by the maintenance director at the time of observation and acknowledged by the administrator at the exit conference on 07/27/16 at 12:03 p.m.</p> <p>3.1-19(b)</p> <p>This deficiency was cited on 05/11/16. The facility failed to implement a systematic plan of correction to prevent recurrence.</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 record review and interview, the facility failed to ensure the inspection report for 43 of 43 fire dampers indicated the 4 year maintenance provided on the inspection report 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</p>	K 0067	<p>monitored to ensure the deficient practice will not recur; i.e., what quality assurance programs will be put into place: the Administrator or designee will monitor all doors requiring automatic latching hardware to ensure they are in place and are working properly on a monthly basis. Results of the monitoring will be reviewed during the facility's Quality Assurance meetings for continued compliance. Monitoring will be ongoing. This deficiency was completed on 7/29/2016.</p> <p>(A)What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? There were no residents affected by this deficiency. (B) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: The Damper inspection report has been obtained from Life Safety Services which</p>	08/02/2016

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	<p>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> <p>Findings include:</p> <p>Based on record review on 07/27/16 at 10:21 a.m. with the maintenance director, from 9:10 a.m. to 1:00 p.m., the Life Safety Systems fire damper inspection report dated 06/23/16 indicated forty three fire dampers were inspected throughout the health care center with a floor plan and circles indicating the location of the fire dampers. Furthermore, the inspection report failed to indicate what type of maintenance was provided during the fire damper inspection and had a statement on the report indicating forty three fire dampers were inspected. The lack of maintenance provided on the fire damper inspection report conducted on 06/23/16 was verified by the maintenance director at the time of record review and acknowledged by the administrator at the exit conference on 07/27/16 at 12:03 p.m.</p>		<p>indicates the type of maintenance provided for each damper. Contractor has ordered parts to repair/replace (7) seven dampers and repairs/replacement will be completed upon parts arrival per Life Safety Services. (C) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Fire dampers will be inspected/and maintenance provided every (4) four years with certified vendor. (D) How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: and by what date the systemic changes will be completed. The (4) four year inspection/maintenance log and all Preventative Logs will be reviewed monthly by Maintenance Director Designee to assure timeliness of inspection/maintenance. The completion date is 8/2/2016.</p>	

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K 0000 Bldg. 02	<p>3.1-19(b)</p> <p>This deficiency was cited on 05/11/16. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 05/11/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>This survey was in conjunction with the PSR for the Comparative Federal Monitoring Survey conducted on 06/15/16.</p> <p>Survey Date: 07/27/16</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>At this PSR 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</p>	K 0000	<p>This plan of correction is prepared and executed because it is required by the provision of state and federal law. Westminster Health Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor are they of such character so as to limit its ability to renderadequate care. This plan of correction shall operate as Westminster Health Care Center credible allegation of compliance. This plan of correction is not meant to establish a standard of care, contract, obligation of position and Westminster Health Care Center reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding</p>	

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	<p>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 81 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 07/29/16 - DA</p>			