STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE AND REHABILITATION CENTER	1751 WESLEY ROAD AUBURN, IN 46706

(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: 06/06/13 Facility Number: 000307 Provider Number: 155666 AIM Number: 100285660 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Wesley Healthcare and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridors and in resident rooms. The	K010000	This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the state allegations. Wesley Healthcare LLC maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents nor are they of such character as to limit our capability to render adequate care. Wesley Healthcare LLC further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare LLC requests a paper compliance for K014, K025, K029, k048, K143, K154, and K155. These were found to be low severity. There was no actual citation of harm to any of the residents.	

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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NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706	

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	facility has a capacity of 69 and had a census of 51 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had two detached metal shipping cargo containers providing facility services including the storage of medical records and maintenance parts that were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/12/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within the exit access for 1 of 4 corridors in the facility. This deficient practice could affect any occupants in the front lobby area. Findings include: Based on observation with the Administrator on 06/06/13 at 12:13 p.m., carpet was installed on the bottom portion of the corridor walls in the front lobby area. Based on an interview with the Administrator at the time of observation, he could provide documentation stating the carpeting meets the requirement for a Class 1 rating as floor covering but no documentation was available to demonstrate the carpet provides a flame spread rating of Class A or Class B. 3.1-19(b)	K010014	K014 The carpet located on the bottom portion of the corridor walls in the front lobby and the dining room has been sprayed with a flame retardant chemical, which gives it a class A flame spread rating. See attached. Administrator will monitor. Completion date of July 5, 2013. Addendum: Please see attatchments K14	07/05/2013

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K010025 SS=E	NFPA 101 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 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that 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. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect any of the 14 residents in the 300 hall. Findings include: Based on an observation with the Administrator on 06/06/13 at 1:25 p.m.,	K010025	K025 The area around the plastic low pressure alarm tube, which penetrates the hall ceiling near room 303 has been sealed by the maintenance man and the Administrator will monitor. Completion Date of July 5, 2013. Addendum: Please see attatchments K25	07/05/2013

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	there was an unsealed penetration measuring one eighth of an inch around a plastic low pressure air alarm tube which penetrated the ceiling near resident room 303. This was acknowledged by the Administrator at the time of observation. 3.1-19(b)			

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K010029 SS=E	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 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 1 of 1 shower rooms used for storage of soiled linen therefore creating a hazardous area was provided with a door that would self close and latch into the frame. This deficient practice could affect one of four smoke compartments. Findings include: Based on observation with the Administrator on 06/06/13 at 1:15 p.m., the central shower room corridor door did self close but it failed to latch into the door frame. One soiled linen cart was stored in the central shower room. Based on an interview with the Administrator at the time of observation, the soiled linen cart is stored in the central shower room until it is collected by someone from the laundry and taken to the laundry room.	K010029	K029 The door to the entrance of the shower room has been repaired and self closes, and latches to the frame. See attached repair order. Administrator will monitor. Completion date of July 5,2013.	07/05/2013

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K010048 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written plan which included the use of the K Class fire extinguisher in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect any residents and staff in and near the kitchen in the event of an emergency. Findings include: Based on a record review with the Administrator on 06/06/13 at 12:30 p.m., the "Fire Evacuation Plan" did not address the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Administrator at the	K010048	K048 There has been an addendum added to the fire safety plan, which addresses the kitchen K class fire extinguisher. See attached addendum. . Administrator will monitor. Completion date of July 5,2013.	07/05/2013

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	time of record review, no other documentation was available for review. 3.1-19(b)			

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K010143 SS=B	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; (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 provide posted signs indicating transferring is occurring in 1 of 1 oxygen transferring locations. This deficient practice was not in a resident care area but could affect staff in the service hall. Findings include: Based on observation with the Administrator on 06/06/13 at 1:10 p.m., the service hall oxygen transferring room lacked the required sign stating transferring is occurring. At the time of observation, the Administrator confirmed the oxygen room was used for oxygen transferring and the door lacked to proper signage.	K010143	K143 Maintenance man has placed a new sign on the oxygen room door that states "Trans Filling in Progress". We have trained our staff how to use the sign when filling portable oxygen tanks. See attached employee in-service and purchase of sign. Administrator will monitor. Completion date of July 5,2013	07/05/2013

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K010154 SS=C	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 protect 51 of 51 residents by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, Section A.9.7.6 explains the individual conducting the fire watch should be specially trained in fire prevention, in the use of fire extinguishers, in notifying the fire department, in sounding the building fire alarm and in understanding the particular fire safety situation for public education purposes. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Watch Policy and Procedure" with the Administrator on 06/06/13 at 12:40 p.m., the facility did have a written policy and	K010154	K154 The Life Safety Director has added an addendum to the fire watch policy and procedure which states that all employee's will be properly trained on our fire watch policy and procedure. See attached addendum and policy and procedure. Administrator will monitor. Completion date of July 05,2013.	07/05/2013

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	procedure for an impaired sprinkler system available for review, but the policy did not state the designated person(s) shall be properly trained in the duties and responsibilities before conducting the fire watch. Based on an interview with the Administrator at the time of record review, it was acknowledged the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall be properly trained in the duties and responsibilities of a fire watch. 3.1-19(b)			

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K010155 SS=C	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 provide a complete written policy for the protection of 51 of 51 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants.	K010155	K155 The Life Safety Director has added an addendum to the fire watch policy and procedure which states that all employee's will be properly trained on our fire watch policy and procedure. See attached addendum and policy and procedure. Administrator will monitor. Completion date of July 05,2013.	07/05/2013

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	Findings include: Based on review of the "Fire Watch Policy and Procedure" with the Administrator on 06/06/13 at 12:40 p.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but the policy did not state the designated person(s) shall be properly trained in the duties and responsibilities before conducting the fire watch. Based on an interview with the Administrator at the time of record review, it was acknowledged the fire watch policy documentation lacked a statement indicating the person(s) conducting the fire watch shall be properly trained in the duties and responsibilities of a fire watch. 3.1-19(b)			