

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155221	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/25/2012
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NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/25/12</p> <p>Facility Number: 000126 Provider Number: 155221 AIM Number: 100266400</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code and Quality Assurance Walk-thru survey, Davis Gardens 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p>	K0000		

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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	<p>This two story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 78 and had a census of 69 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to smoke detector coverage and sprinkler coverage.</p> <p>All areas where the residents have customary access were sprinklered with the exceptions noted in K-56, and all areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 08/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0025 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 openings in a smoke partition, such as a ceiling, were sealed to limit the transfer of smoke. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect visitors, staff and 16 or more residents in the first floor north wing and center second floor smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/25/12 at 2:45 p.m., two ceiling tiles were missing in the first floor utility room and a pipe penetration cutout in a third</p>	K0025	Westminster Village has replaced all ceiling tiles in the areas mentioned. Area around duct penetration will be sealed with fire retardant foam. We will be conducting a Plant staff in service to combat the issue, in service will be held on 8/15/2012, plant staff will be instructed to inform Plant Director or Maintenance Supervisor any time they open a suspended ceiling, staff will ask for an inspection when work is complete, before they go home or move on to a different assignment	08/24/2012			

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	<p>ceiling tile left a two inch gap into the inertial space between the laid in ceiling and floor above, The maintenance director said at the time of observation, he hadn't known the tiles had been removed.</p> <p>Based on observation of the second floor environmental services cart storage/electrical panel room with the maintenance director on 07/25/12 at 3:15 p.m., a ceiling duct penetration was unsealed leaving a one inch gap around the perimeter of the duct. The maintenance director said at the time of observation, he had not seen the gap.</p> <p>3.1-19(b)</p>				

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K0029 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to provide corridor separation from 1 of 6 hazardous areas by a smoke resistant partition or door. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 16 residents in the north first floor smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 07/25/12 at 2:55 p.m. with the maintenance director, the first floor service corridor was used for the storage of three upholstered</p>	K0029	Westminster Village has removed the items from employee corridor. Signs will be placed at each end of the hall informing staff not to store items in the employee hallway. Plant staff will monitor hallway to insure compliance. New doors have been ordered for the Kitchen and employee break room to resolve the egress issue.	08/24/2012

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	<p>chairs and an ottoman, a large cardboard carton of clothing, an unsealed half full paper recycling receptacle with a capacity for more than 50 gallons, and miscellaneous equipment along the length of the corridor. In addition this service corridor included a kitchen with two 24 by 24 inch vents in each of the double doors providing access to it and the employee break room which had hinge sites but no door. The service corridor storage area had no separation from the emergency exit to the public way from the path from the first floor north smoke compartment identified on the emergency exit evacuation diagram provided for review on 07/25/12 at 3:15 p.m. The maintenance director acknowledged at the time of observation and record review, the hazardous service corridor storage and hazards in adjacent rooms had no separation for occupants exiting from the first floor north smoke compartment.</p> <p>3.1-19(b)</p>			

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K0044 SS=E	<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 6 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors staff and 16 residents in the north first floor smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/25/12 at 2:20 p.m., one door in the fire door set separating the north and center first floor smoke compartments was tested twice with the maintenance director. One door in the fire door set failed to latch each time the doors were</p>	K0044	Latch will be repaired or replaced and fire doors will be tested and documented monthly during fire drills to insure all doors latch properly.	08/24/2012			

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	released to close. The maintenance director agreed, at the time of observation, there was a problem with the latching mechanism.  3.1-19(b)				

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K0048 SS=F	<p>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</p> <p>Based on record review and interview, the facility failed to provide a written fire plan which includes the procedures for the use of all types of fire extinguishers in the facility for the protection 69 of 69 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants, visitors and staff in the facility in the event of an emergency when the written fire plan should be immediately</p>	K0048	Plant director will rewrite and revise the fire plan portion of the disaster plan to include the 2 different types of fire extinguishers available for staff to use. Plan will state type of extinguisher, procedures to use the fire extinguisher, and what it can be used on. Westminster staff was in serviced on the use of extinguishers last year in August and each new employee is also in serviced as well. Fire extinguisher use will be reviewed at the next Safety Meeting to be held August 30 th .	08/24/2012			

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	<p>available.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director on 07/25/12 at 5:05 p.m., the written Fire Plan included the duties of staff, including kitchen staff in response to a fire. The policy failed to identify the types of extinguishers in the facility, the fires they are to be used for and the procedures on how to use each type of extinguisher. The manual did not address the relationship of the use of the Class K extinguisher with the hood suppression system. At the time of record review, the maintenance director said he was unaware of the requirement for the fire plan to include extinguisher availability and procedure.</p> <p>3.1-19(b)</p>				

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide complete exit corridor sprinkler coverage for 3 of 9 smoke compartments. This deficient practice affects visitors, staff and 31 residents on the first and second floor north smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/25/12 between 2:00 p.m. and 4:40 p.m., sprinkler protection was not provided for the three by three foot corridor access from the first and second floors to the kitchenettes. The maintenance</p>	K0056	Westminster Village will be contacting Simplex Grinnell to install sprinkler heads in the areas mentioned	08/24/2012			

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	<p>director acknowledged at the time of observations, the exit corridor sprinklers provided no coverage for these areas.</p> <p>Based on observation with the maintenance director on 07/25/12 at 2:35 p.m., no sprinkler coverage was provided in the enclosed area behind gas fueled dryers in the laundry. The maintenance director checked the area thoroughly at the time of observation and agreed no sprinklers had been installed in the area.</p> <p>3.1-19(b) 3.1-19(ff)</p>			

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K0062 SS=F	<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 record review and interview, the facility failed to ensure the fire pumps were continuously maintained and a weekly test to check water flow conditions for 2 of 2 fire pumps was conducted as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 5-3.2.1. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of facility preventive maintenance records with the maintenance director on 07/25/12 at 4:10 p.m., no weekly test of the fire pumps was found. The maintenance director said at the time of record review, he didn't know anything about testing the pumps weekly.</p> <p>3.1-19(b)</p>	K0062	Westminster Village will consult with Simplex Grinnell to instruct plant staff how to perform the weekly test of the fire pump. Plant staff will create a log to document test and copy it monthly to the life safety code binder	08/24/2012

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K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure annual maintenance and monthly checks were provided for 1 of 3 portable fire extinguishers on the second floor. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires that extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance that extinguisher will operate effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect affect visitors, staff and 4 or more</p>	K0064	A list of all fire extinguishers throughout the building has been created this list will be used each month and annually to insure extinguishers are tagged and in good working order. The list will be signed monthly by plant staff and placed in life safety code binder	08/24/2012

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	<p>residents in center second floor smoke compartment where the nurses' station and lounge are located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/25/12 at 3:00 p.m., the annual maintenance tag on the portable fire extinguisher located in the second floor elevator equipment room had a annual service/inspection tags dated 2011 for the date the extinguisher was placed in service. The last documented monthly checks was noted 10/20/11. The maintenance director said at the time of observation, the fire extinguisher checks were noted on these service and inspection tags and it seemed this fire extinguisher had not been maintained.</p> <p>3.1-19(b)</p>				

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient</p>	K0144	Westminster Village will contact Cummins to install a remote manual stop button away from generator. Plant staff will observe and document weekly generator testing also a monthly load test of 30% for a minimum of 30 minutes will be documented to insure proper operation of generator. Plant supervisor will monitor log book to insure proper documentation.	08/24/2012

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NAME OF PROVIDER OR SUPPLIER  DAVIS GARDENS HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 E DAVIS DR TERRE HAUTE, IN 47802
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	<p>practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of the emergency generator on 07/25/12 at 2:50 p.m. with the maintenance director, the emergency stop was located on the generator inside the emergency generator housing. The maintenance director said at the time of observation, there was no remote emergency shut off for the emergency generator.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised</p>			

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	<p>under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the emergency Generator Tests records provided by the maintenance director on 07/25/12 at 3:35 p.m., the records included monthly load testing of the emergency generator until 08/03/11. No load was recorded on the records after that date. The maintenance director said at the time of record review, he did not know why the record was incomplete.</p> <p>3.1-19(b)</p>			

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure an electrical equipment room in 1 of 9 smoke compartments was provided with sufficient access and working space to permit ready and safe operation and maintenance of the equipment. NFPA 70, Article 110.26 requires sufficient access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Table 110.26 (A)(1) requires a minimum of three feet of clear distance from the electrical equipment. This deficient practice affects visitors, staff and 4 or more residents in center second floor smoke compartment where the nurses' station and lounge are located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on</p>	K0147	An in service will be conducted with housekeeping staff to insure they are aware of the regulations and importance of not obstructing access to the electrical panels. The floor in front of the panels will be marked off and a sign placed to make sure the area is free of obstructions.	08/24/2012

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	<p>07/25/12 at 3:00 p.m., an electrical panel room was used for the storage of environmental service carts. The maintenance director acknowledged at the time of observation, the cart had to be removed to access the electrical panels.</p> <p>3.1-19(b)</p>			

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K9999	<p><b>State Findings</b></p> <p><b>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</b></p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(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.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident ' s room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in each resident ' s room before July 1, 2012. This deficient practice</p>			K9999	<p>Battery powered smoke detectors will be ordered and installed in all 40 resident rooms. A weekly test will be documented and placed in life safety code binder. The new smoke detectors will be maintained and tested as suggested by the manufactures guide lines.</p>		08/24/2012

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	<p>could affect 69 residents in the facility.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 07/25/12 between 2:00 p.m. and 4:40 p.m. no smoke detectors were installed in resident rooms. The maintenance director said at the time of observations, he was unaware of the requirement.</p> <p>3.1-19(ff)</p>				