

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2016
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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802
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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: 02/17/16</p> <p>Facility Number: 000139 Provider Number: 155234 AIM Number: 100266410</p> <p>At this Life Safety Code survey, Westridge 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>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 smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 66 and had a census of 44 at the time of this survey.</p>	K 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</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 0017 SS=E Bldg. 01	<p>All areas where the residents have customary access are sprinklered. All areas providing facility services were sprinklered except a detached laundry and a maintenance storage area.</p> <p>Quality Review completed on 02/25/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 ice machine rooms was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous</p>	K 0017	K 017 requires the facility to protect spaces other than patient sleeping rooms, treatment rooms and hazardous areas with electronically supervised automatic smoke detection systems.	03/18/2016

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	<p>areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect any residents near the main entrance.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Director on 02/17/16 at 11:20 a.m., the corridor door had been removed from the ice machine room and the ice machine room was provided with a battery operated smoke alarm. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the ice machine room was not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the Administrator and Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<ol style="list-style-type: none"> 1. No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, an electronically supervised automatic smoke detector will be installed in the ice machine room. 4. As a means of quality assurance, the smoke detector will be added to the preventative maintenance schedule for routine monitoring and annual sensitivity testing. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. 5. The above corrective actions will be completed on or before March 18, 2016. 	

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K 0021 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. Based on observation and interview, the facility failed to ensure 1 of 1 Dutch style kitchen door in the kitchen wall, a hazardous area, would self-close upon activation of the fire alarm system. This deficient practice could affect at least 10 residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director on 02/17/16 at 10:50 a.m., the top door of the Dutch style kitchen door</p>	K 0021	<p>K 021 requires the facility to provide doors in a smoke barrier to be self closing and kept in a closed position unless held open by a release device that automatically closes all such doors upon activation of the fire alarm system.</p> <p>1. No residents were harmed. Staff will be educated on the requirements for the Dutch door between dining room and kitchen.</p>	03/18/2016
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K 0025 SS=D Bldg. 01	<p>was held in the open position with a magnet. Based on an interview with the Maintenance Director the magnet does not release upon activation of the fire alarm system. Additionally, the top section of the kitchen door does not latch into the door frame. At the time of observation, the Maintenance Director confirmed the kitchen and dining room was open to the corridor.</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 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 observation and interview, the facility failed to ensure 1 of 1 ceiling</p>	K 0025	<p>2. All residents who utilize the dining room have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, a magnetic release device was installed on the Dutch door to the kitchen along with a self-latching device connecting the upper and lower portions of the door.</p> <p>4. As a means of quality assurance, the magnetic lock will be added to the preventative maintenance schedule for routine monitoring. Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted.</p> <p>5. The above corrective actions will be completed on or before March 18, 2016.</p> <p>K 025 requires the facility to ensure smoke barriers are</p>	03/18/2016

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K 0038 SS=E Bldg. 01	<p>smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation on 02/17/16 at 11:15 a.m., the Maintenance Director acknowledged there was a one half unsealed ceiling penetration around a phone cable. At 11:45 p.m., the Maintenance Director acknowledged there was a one inch ceiling penetration in the south hall housekeeping closet.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access was arranged so 3 of 9 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires the means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall</p>	K 0038	<p>constructed to provide at least a one half hour fire resistance rating.</p> <ol style="list-style-type: none"> No residents were harmed. All residents have the potential to be affected; thus the following corrective actions have been taken, As a means to ensure ongoing compliance, ceiling penetrations will be sealed with fire rated sealant. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. The above corrective actions will be completed on or before March 18, 2016. <p>K 038 requires the facility to arrange exit access so that all exits are readily accessible at all times.</p> <ol style="list-style-type: none"> No residents were harmed. 	04/01/2016	

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	<p>terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affects residents evacuated through the south, east hall exits and the exit at the end of the east hall.</p> <p>Findings include</p> <p>Based on observation on 02/17/16 at 12:30 p.m., the Administrator and the Maintenance Director confirmed the emergency exit egress sidewalk from the south hall and the east hall joined the emergency exit egress sidewalk from the exit at the end of the east hall. The sidewalk ended at a gate. Based on an interview at the time of observation, the Administrator and the Maintenance Director measured the grassy area from the end of the sidewalk to the public and confirmed the measurement to be 27 feet.</p>		<p>2. All residents have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, the emergency evacuation plan will be revised to direct exit of the east and south halls toward the front parking lot. A sidewalk will be installed from the south exit door directly to the parking lot.</p> <p>4. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted.</p> <p>5. We respectfully request an extension for correction of this deficiency to April 1, 2016 due to the time frame involved in the process of obtaining bids and scheduling the work for the new sidewalk.</p>	

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K 0045 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8</p> <p>Based on observation and interview, the facility failed to provide exterior emergency lighting for 2 of 9 exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect at least 10 south hall residents and residents evacuated through the east lounge exit.</p> <p>Findings include:</p> <p>a. Based on observation and interview on 02/17/16 at 11:50 a.m., the Administrator and the Maintenance Director measured the emergency egress sidewalk that continue alongside the south hall. Emergency exterior lighting was not provided for at least 100 feet alongside the south hall. The sidewalk made a 90 degree angle and continued alongside the</p>	K 0045	<p>K 045 requires the facility to arrange illumination of means of egress so that failure of any single lighting fixture will not leave the area in darkness. 1. No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, additional emergency exterior lighting fixtures will be installed along the east hall. The door at the north patio will be re-designated as a "no emergency exit" doorway, with exit signs adjusted to direct exit toward the door at the end of the north hall. 4. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. 5. The above corrective actions will be</p>	03/18/2016	

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K 0046 SS=C Bldg. 01	<p>east hall for another 100 feet. Based on an interview with the Administrator and the Maintenance Director, emergency exterior lighting was not provided to illuminate the emergency egress sidewalk that continued alongside the east hall.</p> <p>b. Based on observation and interview on 02/17/16 at 12:52 p.m., the emergency egress sidewalk from the north patio exit extended diagonally from the building. Based on an interview with the Maintenance Director at the time of observation, the egress sidewalk measured 130 feet to the public way and was not provided with exterior emergency lighting.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 11 of 11 emergency light fixtures of at least 1 1/2 hour duration were tested annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency lighting system for</p>	K 0046	<p>completed on or before March 18, 2016.</p> <p>K 046 requires the facility to provide automatic emergency lighting of at least 1 1/2 hour duration. 1. No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, the Maintenance Director will be re-educated on preventative maintenance requirements</p>	03/18/2016

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K 0047 SS=E Bldg. 01	<p>not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 02/17/16 during the tour from 11:00 a.m. to 2:08 p.m., eleven battery operated emergency lights were observed throughout the facility. Based on record review at 10:32 a.m., the Maintenance Director confirmed he had not conducted a ninety minute annual test on any of the 11 battery operated emergency lights.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 exit signs</p>	K 0047	<p>including conducting the ninety-minute test of emergency lighting on an annual basis. 4. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted.5. The above corrective actions will be completed on or before March 18, 2016.</p> <p>K 047 requires the facility to</p>	03/18/2016			

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K 0048 SS=F Bldg. 01	<p>near resident room 302 lead to an exit door. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. This deficient practice could affect any of occupant choosing to evacuate through the south hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and the Maintenance Director on 02/17/16 at 11:30 a.m., the direction arrow for the exit sign near resident room 302 indicated the path of egress was to the right beyond the fire barrier doors. Based on an interview with the Administrator and the Maintenance Director at the time of observation, the arrow pointed in the wrong direction and there was not an exit door on the right beyond the fire barrier doors.</p> <p>3.1-19(b)</p> <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>display exit and directional signs with continuous illumination served by the emergency lighting system.</p> <ol style="list-style-type: none"> No residents were harmed. All residents utilizing the south hall exit have the potential to be affected; thus the following corrective actions have been taken, As a means to ensure ongoing compliance, the exit sign on south hall near room 302 has been replaced with a sign appropriate for that location.. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. The above corrective actions will be completed on or before March 18, 2016. 	

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	<p>Based on record review and interview, the facility failed to provide a written plan that included the evacuation of a smoke compartment within the evacuation instructions and a plan that included the activation of a resident room battery operated smoke alarms for 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants in the event of an emergency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> a. Based on a record review with the Administrator and the Maintenance Director on 02/1/16 at 10:28 a.m., the "Fire Disaster Plan" stated during a horizontal evacuation resident will be evacuated beyond the fire barrier doors. The fire barrier doors were identified by the Maintenance Director on a facility 	K 0048	<p>K 048 requires the facility to have a written plan for the protection of all patients and for their evacuation in the event of an emergency.</p> <ol style="list-style-type: none"> 1. No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, the evacuation (floor) plan will be revised to accurately identify fire barrier doors. The Fire Disaster plan will be revised to include instructions for staff response to activation of a resident room battery operated smoke detector. Staff will be educated on these new policies and procedures. 4. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. 5. The above corrective actions will be completed on or before March 18, 2016. 	03/18/2016			

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K 0056 SS=F Bldg. 01	<p>floor plan during the record review process. Based on observation in the attic with the Maintenance Director at 2:00 p.m., it was discovered there was not a fire barrier wall above the cross corridor doors near the main entrance and therefore what he thought and identified as fire barrier doors were a set of cross corridor doors.</p> <p>b. Based on interview during the record review process at 10:45 a.m., the Administrator acknowledged the written fire safety plan did not include staff response to the activation of a resident room battery operated smoke alarm.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>1. Based on observation and interview, the facility failed to ensure that a</p>	K 0056	K 056 requires the facility be protected throughout by an	03/18/2016	

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	<p>complete automatic sprinkler system was provided for 2 of 2 roof overhangs in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or combustible canopies exceeding 4 ft. in width. This deficient practice could affect residents evacuated through the south hall and the emergency exit at the end of the east hall.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director on 02/17/16 at 11:55 a.m., there was an unsprinklered roof overhang made of wood frame construction at the south exit and the end of the east hall exit. The roof overhang was narrow on the ends of the building and came to a point over the exit door. Based on an interview with the Maintenance Director at the time of observation and the roof overhang extended 66 inches from the building at the point.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the sprinkler</p>		<p>approved, supervised automatic sprinkler system.</p> <ol style="list-style-type: none"> No residents were harmed. All residents have the potential to be affected; thus the following corrective actions have been taken, <ol style="list-style-type: none"> As a means to ensure ongoing compliance, <ol style="list-style-type: none"> sprinklers will be installed in the roof overhangs over the south and east exits additional supports will be added to the end of the sprinkler pipes in the Sun Room. ductwork in attic will be inspected and moved off sprinkler pipe As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. The above corrective actions will be completed on or before March 18, 2016. 	

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	<p>system was installed in accordance with the requirements of NFPA 101, 2000 edition, Sections 19.3.5 and 9.7. NFPA 13, 1999 edition, Section 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. These deficient practices could affect any residents in the sunroom.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director on 02/17/16 at 10:59 a.m., measurement of the sprinkler pipe between the last support and the end of the pipe where a sprinkler head was installed measured 36 inches on the sprinkler there above the store room and 41 inches above the windows. The Maintenance Director provided the measurements at the time of observations.</p> <p>3.1-19(b)</p> <p>3. Based on observation, the facility failed to ensure 1 of 1 sprinkler systems</p>			

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K 0062 SS=F Bldg. 01	<p>was properly maintained in accordance with NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.</p> <p>Note: NFPA 25, 2-2.2 requires that sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation and interview on 02/17/16 at 1:30 p.m. to 1:40 p.m., the Maintenance Director confirmed there was a section of flexible ductwork supported by the four inch sprinkler pipe in the attic near the east hall fire barrier wall and in the attic at the end of the east hall.</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>			

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K 0064 SS=E Bldg. 01	<p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review on 02/17/16 at 10:35 a.m., the Maintenance Director acknowledged an internal pipe inspection had not be conducted since the inspection completed by Elwood Fire on 06/17/09.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p>	K 0062	<p>K 062 requires the facility's automatic sprinkler system be continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <ol style="list-style-type: none"> No residents were harmed. All residents have the potential to be affected; thus the following corrective actions have been taken, As a means to ensure ongoing compliance, an internal pipe inspection of the sprinkler system will be performed. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. The above corrective actions will be completed on or before March 18, 2016. 	03/18/2016

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	<p>Based on observation and interview, the facility failed to inspect 1 of 1 Maintenance office and 2 of 2 kitchen fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious physical damage or condition to prevent its operation. This deficient practice could affect any at least 10 residents in the dining room and any number of facility staff.</p> <p>Findings include:</p> <p>Based on observations on 02/17/16 at 11:10 a.m., the Maintenance Director acknowledged the monthly inspection tag for the fire extinguisher in the maintenance office indicated the fire extinguisher received a monthly inspection in November 2015 only. At 1:21 p.m., the Maintenance Director acknowledged the ABC fire extinguisher</p>	K 0064	<p>K 064 requires the facility to have portable fire extinguishers installed, inspected, and maintained.</p> <ol style="list-style-type: none"> No residents were harmed. All residents have the potential to be affected; thus the following corrective actions have been taken, As a means to ensure ongoing compliance, the Maintenance Director will be re-educated on preventative maintenance requirements including monthly inspections of fire extinguishers. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted. The above corrective actions will be completed on or before March 18, 2016. 	03/18/2016

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K 0066 SS=E Bldg. 01	<p>in the kitchen last monthly inspection was August, 2015 and the K-Class last monthly inspection was July, 2015.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 temporary resident and 1 of 1 resident/staff smoking areas were properly maintained and provided with a self-closing trash receptacle used to empty ashtrays only.</p>	K 0066	<p>K 066 requires the facility adopt smoking regulations for staff and residents.</p> <p>1. No residents were harmed.</p>	03/18/2016

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K 0074 SS=E Bldg. 01	<p>This deficient practice could affect residents evacuated from the north patio exit.</p> <p>Findings include:</p> <p>Based on observation and interview on 02/17/16 at 12:15 p.m., the Administrator and Maintenance Director acknowledged there were at least 25 cigarette butts discarded on the ground in the temporary resident smoking area and at least 30 cigarette butts discarded on the ground in the resident/staff smoking area.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in</p>		<p>2. All residents who utilize the smoking area have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, residents and staff who smoke will be re-educated on the smoking policy including appropriate disposal of cigarette butts.</p> <p>4. As a means of quality assurance, the Administrator or designee will visually inspect resident/staff smoking area weekly times 4 weeks, then monthly times 3 months, then quarterly until compliance is maintained for 2 consecutive quarters. The audits and any corrective actions taken will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted,</p> <p>5. The above corrective actions will be completed on or before March 18, 2016.</p>	

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	<p>accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 5 of 56 resident rooms and 1 of 1 activity room were flame retardant. This deficient practice could affect at least 10 residents.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director on 02/17/16 from 11:15 a.m. to 2:10 p.m., the window coverings installed at the windows of resident rooms 309, 310, 317, 212, 203 and the activity room lacked attached documentation confirming they were inherently flame retardant. Based on</p>	K 0074	<p>K 074 requires the facility's draperies, curtains and other loosely hanging fabrics serving as furnishings be flame resistant.</p> <ol style="list-style-type: none"> No residents were harmed. All residents have the potential to be affected; thus the following corrective actions have been taken, As a means to ensure ongoing compliance, drapes and curtains will be treated with flame retardant which meets NFPA standards for this setting. As a means of quality 	03/18/2016

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K 0130 SS=F Bldg. 01	<p>interview with the Maintenance Director at 11:40 a.m., there was no documentation regarding flame retardancy for these window coverings available for review.</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 ensure a battery testing and replacement program was provided to ensure 56 of 56 single station smoke alarms would operate. This deficient practice affects all 44 residents.</p> <p>Findings include:</p> <p>Based on record review and interview on 02/17/16 at 10:42 a.m., the Maintenance Supervisor acknowledged the facility did not have documentation of a battery testing program for the 56 single station smoke alarms installed in resident rooms.</p> <p>3.1-19(b)</p>	K 0130	<p>assurance, a log will be maintained of the date of application of flame retardant treatments for draperies and curtains used in the facility. The log will be reviewed at the monthly Quality Assurance meeting and the plan of action adjusted accordingly, if warranted,</p> <p>5. The above corrective actions will be completed on or before March 18, 2016.</p> <p>K 130 requires the facility to ensure a battery testing and replacement program for single station smoke alarms.</p> <p>1. No residents were harmed.</p> <p>2. All residents have the potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, battery testing and replacement of single station smoke alarms will be added to the preventative maintenance schedule.</p> <p>4. As a means of quality assurance, Preventative</p>	03/18/2016			

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K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (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) Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect 1 of 4 smoke compartments.</p> <p>Findings include:</p>	K 0143	<p>Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted.</p> <p>5. The above corrective actions will be completed on or before March 18, 2016.</p> <p>K 143 requires the facility provide oxygen transfer locations with continuous mechanical ventilation.</p> <p>1. No residents were harmed. 2. All residents have the</p>	03/18/2016

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K 0144 SS=F Bldg. 01	<p>Based on an observation and interview on 02/17/16 at 1:15 p.m., the Maintenance Director confirmed the mechanical ventilation in the oxygen transfilling/storage room which contained several large stationary container of liquid oxygen could be shut off by a switch located in the oxygen transfilling room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers</p>	K 0144	<p>potential to be affected; thus the following corrective actions have been taken,</p> <p>3. As a means to ensure ongoing compliance, the vent in north hall oxygen transfer closet has been direct wired with no switch for continuous operation.</p> <p>4. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted.</p> <p>5. The above corrective actions will be completed on or before March 18, 2016.</p> <p>K 144 requires the facility provide oxygen transfer locations with continuous mechanical ventilation.</p> <p>1. No residents were harmed.</p> <p>2. All residents have the potential to be affected; thus the following corrective actions have</p>	03/18/2016

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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802		
(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>Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log with the Maintenance Director on 02/17/16 at 10:30 a.m., the facility was unable to provide documentation of a generator load test for the previous year. Based on an interview with the Maintenance Director at the time of record review, he had not been give directions on how to conduct a monthly load test.</p> <p>3.1-19(b)</p>		<p>been taken,</p> <p>3. As a means to ensure ongoing compliance, the Maintenance Director will be re-educated on preventative maintenance requirements including monthly requirement for running the generator under load.</p> <p>4. As a means of quality assurance, Preventative Maintenance logs will be reviewed monthly during Quality Assurance meetings with the plan of action adjusted accordingly if warranted.</p> <p>5. The above corrective actions will be completed on or before March 18, 2016.</p>		