

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2016
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NAME OF PROVIDER OR SUPPLIER  WASHINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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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: 08/26/16</p> <p>Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340</p> <p>At this Life Safety Code survey, Washington Healthcare 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 75 at</p>	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation, This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Survey Review on or after 9/25/16	

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 0018 SS=E Bldg. 01	<p>the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building for storage of supplies which was not sprinklered.</p> <p>Quality Review completed on 09/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 50 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing,</p>	K 0018	<b>What corrective action(s) will be accomplished for those residents found to</b>	09/15/2016

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	<p>latching and would resist the passage of smoke. This deficient practice could affect 22 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, the following was noted:</p> <p>a. the corridor door to the Marketing/Admissions Office was propped in the fully open position with a wedge placed on the floor.</p> <p>b. the corridor door to Room 301 failed to latch into the door frame because the latching mechanism did not protrude into the latching plate.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned corridor doors each had an impediment to closing, latching and would not resist the passage of smoke.</p> <p>3.1-19(b)</p>		<p><b>have been affected by the deficient practice?</b> Corridors will provide a means suitable for keeping the door closed. Doors will close and latch to resist the passage of smoke. The wedge was removed from floor that propped open Marketing and Admissions office. The corridor door to room 301 repaired to allow door to latch into latching plate in door frame. <b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> Environmental Supervisor/ Maintenance Director to ensure that no doors in facility are propped open and that doors that do not latch properly are identified during morning rounds and repaired if</p>	

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			necessary. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</b> Environmental Supervisor/ Maintenance Director to ensure that no doors in facility are propped open and that doors that do not latch properly are identified during morning rounds and repaired if necessary. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and	

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K 0025 SS=E Bldg. 01	<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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, the following was noted: a. the one inch annular space surrounding</p>	K 0025	<p>monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Maintenance Office, Therapy Bathroom and activities office ceilings caulked and sealed with approved material to ensure that smoke barrier is maintained to provide at least one half hour fire resistance rating.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and</b></p>	09/15/2016

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	<p>two one inch in diameter conduits and two four inch in diameter conduits which penetrated the ceiling of the Maintenance Office were each not filled with an approved material for maintaining the smoke resistance of a smoke barrier and exposed the attic above.</p> <p>b. the one inch annular space surrounding a one inch in diameter pipe which penetrated the ceiling of the south bathroom in Therapy was not filled with a approved material for maintaining the smoke resistance of a smoke barrier and exposed the attic above.</p> <p>c. the one inch annular space surrounding a one inch in diameter conduit which penetrated the ceiling of Activities Office was not filled with a approved material for maintaining the smoke resistance of a smoke barrier.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned holes in the ceiling smoke barrier did not maintain at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p>		<p><b>whatcorrective action will be taken?</b> Maintenance director observed ceilings for holes or spaces that does not provide at least one half hour fire resistance rating throughout facility and none were located. All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes you willmake to ensure that the deficient practice does not recur.</b> MaintenanceDirector/ designee to inspect ceiling for holes or any spaces after any vendoror contractor repairs to ensure that no gaps or holes are created or left not providing smoke barrier.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficientpractice will not recur, i.e., what quality assurance program will be put intoplace.</b> To ensure compliance, the MaintenanceDirector/Designee is responsible for the completion of the Fire Safety CQI toolweekly times 4 weeks and monthly for six months. The results of these auditswill be reviewed by the CQI committee overseen by the ED. If threshold of95% is not achieved an action plan will be developed to ensure compliance.</p>	

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K 0046 SS=C Bldg. 01	<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 record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 3 of 3 battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 1/2 -hr 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 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights Testing for 2015" and "Preventive Maintenance This Month for 2016" with the Maintenance Director from 9:15 a.m. to 11:50 a.m. on</p>	K 0046	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Facility will maintain and have available for review documentation of an itemized list of an annual test for each battery powered emergency lighting system for not less than 1.5 hour duration. <b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> All residents have the potential to be affected by this alleged deficient practice. All Emergency Battery operated lights will be tested in accordance and log maintained. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> All Emergency Battery operated lights will be tested in accordance and log maintained. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> To ensure compliance, the Maintenance Director/Designee is</p>	09/15/2016
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K 0050	<p>08/26/16, documentation of an itemized list of monthly functional testing for battery powered emergency lights after August 2015 was not available for review. In addition, documentation of an itemized list of an annual test for each battery powered emergency lighting system for not less than 1 ½ -hr duration was also not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, three battery powered lights were located in the facility and each light illuminated when its respective test button was pushed. Based on interview at the time of record review and of the observations, the Maintenance Supervisor acknowledged documentation of monthly functional testing after August 2015 and annual testing for not less than 1 ½ -hr duration for each of three battery powered emergency lights in the facility was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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SS=F Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:50 a.m. on 08/26/16, documentation of a fire drill conducted on the third shift in the third quarter (July, August, September) 2015 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated additional fire drill documentation not was available for review and acknowledged documentation of a fire</p>	K 0050	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Fire drills will be conducted on third shift and documented. Fire Drills conducted after 6:00 am but before 9:00 pm will include activation of the fire alarm system and transmission of the fire alarm signal. Fire drills will be conducted at unexpected times under varying conditions.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> All residents have the potential to be affected by this alleged deficient practice</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the</b></p>	09/15/2016

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	<p>drill conducted on the third shift in the third quarter 2015 was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:50 a.m. on 08/26/16, documentation for the second shift fire drill conducted on 11/30/15 at 8:00 p.m. did not include activation of the fire alarm system and transmission of</p>		<p><b>deficient practice does not recur</b></p> <p>Documentation to be reviewed at monthly CQI meetings to ensure that monthly documentation is maintained and available for review.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>the fire alarm signal. Documentation for the aforementioned second shift fire drill stated "No" in response to "was action taken to activate the fire alarm system" and "did the system sound throughout the facility." In addition, the fire drill documentation stated "did silent had over half the bldg were asleep anyway." Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation for the aforementioned second shift fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(ac)</p> <p>3. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:15 a.m. to 11:50 a.m. on</p>			

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K 0052 SS=F Bldg. 01	<p>08/26/16, three of four first shift (6:00 a.m. to 2:00 p.m.) fire drills conducted on 07/31/15, 01/31/16, and 04/27/16 were conducted at, respectively, 10:05 a.m., 10:35 a.m. and 10:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year</p>	K 0052	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> All facility smoke detectors will be maintained in accordance with the applicable requirements of NFPA 72,7-3.2. Smoke detector sensitivity testing</p>	09/20/2016

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	<p>thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer's calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity</p>		<p>within the most recent two year period for all facility fire alarms system smoke detectors will be available for review. <b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> All residents have the potential to be affected by this alleged deficient practice. Record of sensitivity testing to smoke alarms system testing will be maintained by the Maintenance Director. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Maintenance Director/Designee will ensure that Documentation of smoke detector sensitivity testing within the most recent two year period for all facility fire alarm system smoke detectors are available for review to ensure deficient practice does not recur. Facility Maintenance Director/Executive Director will continue ensure inspections are conducted on a regularly quarterly scheduled basis and any deficiencies noted at the time of inspection will be addressed to make sure we remain in compliance. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> To ensure</p>	

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	<p>range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Sensitivity Test" and "Field Work Order" documentation dated 08/18/15 during record review with the Maintenance Supervisor from 9:15 a.m. to 11:50 a.m. on 08/26/16, documentation of smoke detector sensitivity testing within the most recent two year period for all facility fire alarm system smoke detectors was not available for review. The aforementioned documentation listed sensitivity testing for three facility duct detectors with the "Field Work Order" documentation stating "reinspected and performed a sensitivity test on three duct detectors that failed to operate correctly during last quarterly inspection. All tests satisfactory." Based on interview at the time of record review, the Maintenance Supervisor stated additional smoke detector sensitivity testing documentation was not available for review and acknowledged sensitivity testing documentation for all facility fire alarm system smoke detectors within the most recent two year period was not available for review.</p>		<p>compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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K 0062 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, it could not be assured 1 of 1 sprinkler systems was kept in reliable operating condition. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of P.I.P.E. Inc. "Proposal For Fire Protection"</p>	K 0062	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Accelerator to be installed to the dry system to assist the DPV to trip faster as required by code. Vendor contacted and work approved. Documentation for quarterly sprinkler inspections to be readily available for review. Sprinkler heads in Med Prep room and Bathing room on 200 hall equipped with escutcheon.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b></p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Maintenance Director and Environmental Services Supervisor inspected facility for sprinkler heads not equipped with</p>	09/20/2016

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	<p>documentation dated 07/25/16 during record review with the Maintenance Supervisor from 9:15 a.m. to 11:50 a.m. on 08/26/16, it was stated "during your July 2016 fire sprinkler inspection trip test of automatic dry pipe valve, it failed to trip satisfactory due to excessive time to release air pressure. We recommend the installation of an accelerator to the dry system to assist the DPV to trip faster as required by code." Based on interview at the time of record review and at the exit conference at 2:45 p.m., the Executive Director and the Maintenance Supervisor stated the facility is moving forward with P.I.P.E.'s proposal but acknowledged the installation of an accelerator and retesting had not been performed on or after 07/25/16.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and</p>		<p>escutcheons or maintained and none found.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>Maintenance Director to maintain and have available for review Sprinkler inspection documentation. Executive Director and Maintenance Director to ensure that proposals for service are followed up on. Maintenance Director to ensure that all sprinkler heads are maintained. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:15 a.m. to 11:50 a.m. on 08/26/16, documentation of quarterly sprinkler inspection for the first quarter (January, February, March) 2016 was not available for review. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, hanging tags affixed to the sprinkler system riser by Armour Fire Protection and P.I.P.E. Inc. to document sprinkler inspections did not indicate a quarterly sprinkler inspection was documented for the first quarter of 2016. Based on interview at the time of record review and of the observations, the Maintenance Supervisor acknowledged documentation of quarterly sprinkler inspection for the first quarter (January, February, March) 2016 was not available for review.</p>			

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	<p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 2 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 22 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, the following sprinkler locations were not equipped with an escutcheon:</p> <ul style="list-style-type: none"> <li>a. the Med Prep room at the front nurse's station by Room 308.</li> <li>b. the Bathing Room in the 200 Hall.</li> </ul> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned automatic sprinkler locations each had a missing escutcheon.</p> <p>3.1-19(b)</p>			

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K 0069 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect four staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of 360 Services "Report #: FP" documentation dated 03/08/16 during record review with the Maintenance Supervisor from 9:15 a.m. to 11:50 a.m. on 08/26/16, documentation of semiannual hood extinguishing systems inspection six months prior to 03/08/16 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged</p>	K 0069	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Inspection conducted to hood extinguishing system and documentation maintained and available for review. Kitchen exhaust system inspected semiannually and documentation maintained for review. <b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> All residents have the potential to be affected by this alleged deficient practice. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Maintenance Director/Designee will maintain log to ensure that hood extinguishing systems are inspected and serviced every 6 months and documentation available for review. Maintenance Director or designee to ensure Kitchen exhaust system inspected semi-annually and documentation available for</p>	09/15/2016

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	<p>documentation of semiannual hood extinguishing systems inspection six months prior to 03/08/16 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal,</p>		<p>review. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>it shall not be coated with powder or other substance. This deficient practice could affect four staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of 360 Services "Service Report" documentation dated 05/24/16 during record review with the Maintenance Supervisor from 9:15 a.m. to 11:50 a.m. on 08/26/16, documentation of semiannual kitchen exhaust systems inspection six months prior to 05/24/16 was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, stickers affixed to the kitchen range hood indicated hood extinguishing systems inspections were conducted by 360 Services on 05/24/16 and in August 2015. Based on interview at the time of record review and of the observation, the Maintenance Supervisor acknowledged documentation of semiannual kitchen exhaust systems inspection six months prior to 05/24/16 was not available for review.</p> <p>3.1-19(b)</p>			

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K 0144 SS=C Bldg. 01	<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>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 5 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent</p>	K 0144	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Complete written record of weekly inspections for the starting batteries for the emergency generator maintained by maintenance director and made available for review. Monthly load testing conducted and complete records maintained, documented, and available for review.</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not</b></p>	09/15/2016

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	<p>of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. 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 could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" documentation during record review with the Maintenance Supervisor from 9:15 a.m. to 11:50 a.m. on 08/26/16, monthly load testing conducted on 11/03/15, 12/12/15, 04/06/16, 07/22/16 and 08/06/16 for the diesel fired emergency generator did not document the generator was load tested under operating temperature conditions, at not less than 30 percent of the EPS nameplate rating or at a loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance</p>		<p><b>recur</b></p> <p>Maintenance director/ designee to review log or complete written records to ensure that <b>weekly inspections for the starting batteries for the emergency generator are maintained and made available for review to ensure this doesn't recur.</b> Maintenance Director to ensure Monthly load testing conducted and complete records maintained, documented, and available for review to ensure this deficient practice does not recur.<b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the FireSafety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed</p>	

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	<p>Supervisor acknowledged documentation of a complete record for monthly load testing for the aforementioned five month period was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 2 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 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 by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>		to ensure compliance.	

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K 0147 SS=E Bldg. 01	<p>Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation during record review with the Maintenance Supervisor from 9:15 a.m. to 11:50 a.m. on 08/26/16, documentation of weekly inspections of the starting batteries for the emergency generator for the two week period of 03/14/16 through 03/28/16 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the aforementioned two week period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 1. Based on observation and interview, the facility failed to ensure 1 of 1</p>	K 0147	<b>What corrective action(s) will be accomplished for those residents found to have been</b>	09/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155383		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2016	
NAME OF PROVIDER OR SUPPLIER  WASHINGTON HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231			
(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>extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the Assistant Director of Nursing Services Office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, a refrigerator was plugged into a power strip in the Assistant Director of Nursing Services Office.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged a power strip was being used as a substitute for fixed wiring in the Assistant Director of Nursing Services Office.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>		<p><b>affected by the deficient practice?</b> Power strip removed from Assistant Director of Nursing Services Office. Managers educated by maintenance director on power strips and expectation of not using to substitute for fixed wiring. West soiled utility room housing electrical apparatus cleared of clutter and access and working space maintained. <b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> All residents have the potential to be affected by this alleged deficient practice. Maintenance Director searched rooms for power strips used as a substitute for fixed wiring with no findings. Areas that house electrical apparatus inspected by maintenance director to ensure access and working space is maintained with no findings. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Maintenance Director/ designee to inspect rooms periodically for power strips that are being used as a substitute for fixed wiring. Maintenance director / designee to inspect electrical rooms daily during rounds to ensure that main electrical rooms ensure access and working space. <b>How the corrective action(s) will be monitored to</b></p>				

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	<p>the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 2 main electrical rooms. NFPA 70, Article 100-26(a) states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 100-26(a) (1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 100-26(b) states the working space required by this section shall not be used for storage. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the west soiled utility room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 2:20 p.m. on 08/26/16, a mobile housekeeping cart, a cardboard box, three mops and three buffer pads were stored up against the electrical panel in the west soiled utility room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the working space in front of the electrical panel in the west soiled</p>		<p><b>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	utility room was used for storage.  3.1-19(b)				