

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155135	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/31/2015
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NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DR BEDFORD, IN 47421
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K 000 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: 03/31/2015</p> <p>Facility Number: 000060 Provider Number: 155135 Aim Number: 100266600</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code Survey, Westview Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a partial basement 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</p>	K 000	Westview Nursing and Rehabilitation Center would like to ask for a Paper Compliance Review	
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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 020 SS=D Bldg. 01	<p>corridors and spaces open to the corridors. Resident sleeping rooms in Cottage Hall are provided with smoke detectors hard wired to the fire alarm system. Battery operated smoke detectors are installed in all other resident sleeping rooms. The facility has a capacity of 95 and had a census of 74 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has one detached storage building which was not sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 attic access vertical openings were protected as appropriate for the fire resistance rating of the barrier. LSC 19.3.1.2 states doors in a stair enclosure shall be self closing and shall normally be kept in the closed position. This deficient practice could</p>	K 020	<p>K 020 Westview What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·The attic access door for the retractable stair assembly in the ceiling was enclosed with a construction of a fire resistance rating for at least one hour on</p>	04/20/2015

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K 029 SS=E Bldg. 01	<p>affect 5 staff and visitors in the service corridor outside of Dietary.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:00 p.m. on 03/31/15, the attic access door for the retractable stair assembly in the ceiling was a nonrated wood door and was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the attic access door for the retractable stair assembly in the ceiling was a nonrated wood door and was not equipped with a self closing device.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved</p>		<p>Wednesday, April 1, 2015.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> All attic access doors were checked to ensure they all have an enclosed construction with a fire resistance rating of at least one hour that so no residents or staff could have potential to be affected by the alleged deficient practices. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Maintenance Supervisor and staff were educated on 04/01/15 by the ED/designee on K 020 NFPA 101 Life Safety Code Standard. <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> All attic access doors will be checked monthly times 6 months to ensure they have an enclosed construction with a fire resistance rating of at least one hour. These audits will be reviewed by the CQI committee overseen by the ED/designee. 		

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	<p>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 ensure 1 of 8 hazardous areas such as fuel fired heater rooms were separated from other spaces by self closing doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the mechanical room by the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:00 p.m. on 03/31/15, the mechanical room by the entrance to the Therapy Room contained one natural gas fired water heater. The entry door to the mechanical room from the corridor was not equipped with a self closing device to self close and latch the door into the door frame. Based on interview at the time of observation, the</p>	K 029	<p>K 029 Westview What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Maintenance installed a self closing device on the entry door to the mechanical room by the entrance to the Therapy Room which contains on natural gas fired water heater on Wednesday, April 1, 2015. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? ·Maintenance staff checked all 7 hazardous areas such as fuel fired heater rooms which are separated from other spaces by self closing doors to ensure that we are meeting K 029 NFPA 101 Life Safety Code Standard so no other residents or staff can be affected by the alleged deficient practices. What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	04/20/2015			

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K 062 SS=D Bldg. 01	<p>Maintenance Supervisor acknowledged the entry door to the aforementioned hazardous room was not equipped with a self closing device to self close and latch the door into the door frame.</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> <p>Based on observation and interview, the facility failed to ensure 1 of over 100 sprinklers which was covered with corrosion was replaced. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler</p>	K 062	<p>practice does not recur?</p> <ul style="list-style-type: none"> Maintenance Supervisor and staff were educated on 04/01/15 by the ED/designee on K 029 NFPA 101 Life Safety Code Standard. <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> All 7 doors will be checked monthly times 6 months to ensure they have self closing devices which are in working order to meet K 029 NFPA 101 Life Safety Code Standard. These audits will be reviewed by the CQI committee overseen by the ED/designee. <p>K 062 Westview What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Maintenance called Dalmatian Fire, INC on Wednesday, April 1, 2015 to schedule an appointment to replace the corroded sprinkler. On Monday, April 13, 2015 Dalmatian Fire, INC visited the facility and replace the corroded sprinkler. <p>How other residents having</p>	04/20/2015

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K 147 SS=D Bldg. 01	<p>shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 5 staff and visitors in the vicinity of the Biohazard Room near the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:00 p.m. on 03/31/15, the sprinkler located in the Biohazard Room near the service corridor was completely covered in green corrosion. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned sprinkler was completely covered in green corrosion.</p> <p>3.1-19(b)</p> <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>the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> ·Maintenance staff checked all sprinkles to ensure that they are in reliable operating condition meeting K 062 NFPA 101 Life Safety Code Standard so no residents or staff could have the potential to be affected by the alleged deficient practices. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Maintenance Supervisor and staff were educated on 04/01/15 by the ED/designee on K 062 NFPA 101 Life Safety Code Standard. <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·All sprinkles will be checked monthly times 6 months to ensure they are meeting K 062 NFPA 101 Life Safety Code Standard. ·These audits will be reviewed by the CQI committee overseen by the ED/designee. 	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, 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 5 staff and visitors in the vicinity of the Breakroom near the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:20 a.m. to 2:00 p.m. on 03/31/15, a refrigerator and a microwave oven were plugged into a power strip in the Breakroom near the service corridor. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p> <p>3.1-19(b)</p>	K 147	<p>K 147 Westview</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Maintenance immediately removed the power strip in the breakroom and plugged the refrigerator and microwave in a wall socket. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> Maintenance staff checked all refrigerators and microwaves to ensure that we are meeting K 0147 NFPA 101 Life Safety Code Standard so no residents or staff could have the potential to be affected by the alleged deficient practices. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Maintenance Supervisor and staff were educated on 04/01/15 by the ED/designee on K 147 NFPA 101 Life Safety Code Standard. <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> All refrigerators and microwaves will be checked monthly times 6 months to ensure they are meeting K 0147 NFPA 	04/20/2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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			101 Life Safety Code Standard. ·These audits will be reviewed by the CQI committee overseen by the ED/designee.		