

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/12/2016
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NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222
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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: 07/12/16</p> <p>Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410</p> <p>At this Life Safety Code survey, Westpark a Waters Community 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 consisted of two sections: the original section determined to be Type III (200) construction and the Addition was determined to be Type V (000) construction. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the</p>	K 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.</p> <p>Facility is requesting paper compliance for all deficiencies in this POC.</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 0029 SS=E Bldg. 01	<p>corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The entire facility was surveyed as Type V (000) construction. The facility has a capacity of 89 and had a census of 50 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. The facility has two detached storage sheds which were not sprinklered.</p> <p>Quality Review completed on 07/14/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 7 hazardous areas such as fuel fired heater rooms were separated from other areas by smoke resistant partitions. This deficient practice could affect 10 residents, staff</p>	K 0029	<p>K 029 NFPA 101 Life Safety Code Standard</p> <p>It is the intent of this facility to separate hazardous areas such as, fuel fired heater rooms, by smoke resistant partitions.</p>	07/29/2016			

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K 0046	<p>and visitors in the vicinity of the Janitor's Closet by the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Administrator, Maintenance Director and Housekeeping Manager during a tour of the facility from 11:25 a.m. to 12:50 p.m. on 07/12/16, three ceiling tiles were not in place in the suspended ceiling in the Janitor's Closet by the kitchen which contained four natural gas fired water heaters. The west wall of the Janitor's Closet did not extend to the roof deck above the suspended ceiling. As a result, the missing ceiling tiles in the suspended ceiling did not separate this hazardous area from other areas by smoke resistant partitions. Based on interview at the time of observation, the Maintenance Director acknowledged the missing ceiling tiles in the aforementioned Janitor's Closet did not separate this hazardous areas from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>A. ACTIONS TAKEN:</p> <p>1 The aforementioned janitor's closet that was missing three ceiling tiles has been equipped with ceiling tiles and separates this hazardous area from other area by smoke resistant partitions.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1 A 100 percent audit was completed on ceiling tiles with no other findings. No residents were affected.</p> <p>C. MEASURES TAKEN:</p> <p>1 The Maintenance director/designee will complete a monthly audit on all ceiling tiles as a part of the monthly preventative maintenance program and any issues will be immediately addressed.</p> <p>D. HOW MONITORED:</p> <p>1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing.</p>		

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SS=E Bldg. 01	<p>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 1 of 13 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 1/2 -hr. duration.</p> <p>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-Test Log for 2015 and 2016" and " Emergency Light at Generator Testing Monthly and Yearly" documentation with the Maintenance Director and Housekeeping Manager from 9:10 a.m. to 11:25 a.m. on 07/12/16, documentation of an annual test for the battery powered emergency</p>	K 0046	<p>K 046 NFPA 101 Life Safety Code Standard</p> <p>It is the intent of this facility to provide periodic testing of Emergency lighting equipment 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 hour duration.</p> <p>A. ACTIONS TAKEN: 1 Annual testing for not less than 1 1/2 hour duration for the battery powered emergency light located at the emergency generator was conducted along with monthly testing of all battery powered emergency lights.</p> <p>B. OTHERS IDENTIFIED: 1 A 100 percent audit was completed on all battery operated emergency lights with no findings. No residents were affected.</p> <p>C. MEASURES TAKEN: 1 The Maintenance director/designee will complete monthly and annual testing on all battery operated emergency lights and document per policy. A complete audit on all battery</p>	07/29/2016

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	light at the emergency generator location for not less than 1 ½ -hr. duration for the most recent twelve month period was not available for review. Documentation of monthly testing of the battery powered emergency light at the emergency generator location was moved from "Battery Operated Emergency Lights-Test Log for 2015" to "Emergency Light at Generator Testing Monthly and Yearly" for 2016. Neither of the testing logs documented an annual test for the battery powered emergency light at the emergency generator location for not less than 1 ½ -hr. duration for the most recent twelve month period. Based on observations with the Administrator, Maintenance Director and Housekeeping Manager during a tour of the facility from 11:25 a.m. to 12:50 p.m. on 07/12/16, a total of thirteen battery operated emergency lights were located in the facility and each battery operated emergency light operated when their respective test button was pushed. Based on interview at the time of record review and of the observations, the Maintenance Director acknowledged documentation of annual testing for 1 ½ -hr. duration for the battery operated emergency light at the emergency generator location for the most recent twelve month period was not available for review.		operated emergency lights will be a conducted monthly and annually as part of the monthly preventative maintenance program. D. HOW MONITORED: 1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing				

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K 0064 SS=E Bldg. 01	<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> <p>1. Based on observation and interview, the facility failed to document inspection of 3 of 15 portable fire extinguishers in the facility 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 or physical damage or condition to prevent its operation. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator, Maintenance Director and</p>	K 0064	<p>K 064 NFPA 101 Life Safety Code Standard</p> <p>It is the intent of this facility to inspect all portable fire extinguishers in the facility each month and to ensure that all fire extinguishers are installed correctly.</p> <p>A. ACTIONS TAKEN:</p> <p>1 All facility portable fire extinguishers have been inspected and documented per policy. The portable fire extinguisher in the janitor's closet by the kitchen has been lowered to not being more than (60 inches) above the floor.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1 No residents were affected</p> <p>C. MEASURES TAKEN:</p> <p>1 A 100 percent audit of the facilities fire extinguishers have been audited to ensure that all fire extinguishers have been inspected and documented. No additional findings. The Maintenance director/designee will complete a</p>	07/29/2016

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	<p>Housekeeping Manager during a tour of the facility from 11:25 a.m. to 12:50 p.m. on 07/12/16, the portable fire extinguisher in the kitchen by the range hood, in the Janitor's Closet by the kitchen and in the Laundry each had an inspection tag affixed to the extinguisher which indicated an annual inspection was conducted in February 2016. However, a monthly inspection was not documented for each of the aforementioned three portable fire extinguisher locations for the four month period of March 2016 through June 2016. Based on interview at the time of the observations, the Administrator stated no other monthly fire extinguisher inspection documentation was available for review and acknowledged a monthly inspection for the aforementioned three portable fire extinguishers was not documented for the four month period of March 2016 through June 2016.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 15 portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60</p>		<p>monthly audit on all fire extinguishers as a part of the monthly preventative maintenance program and any issues will be immediately addressed</p> <p>D. HOW MONITORED 1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing</p>	

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K 0076 SS=E Bldg. 01	<p>inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect 10 residents in the vicinity of the Janitor's Closet by the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Administrator, Maintenance Director and Housekeeping Manager during a tour of the facility from 11:25 a.m. to 12:50 p.m. on 07/12/16, the portable fire extinguisher in the Janitor's Closet by the kitchen was affixed to the south wall and the top of the extinguisher was six feet (72 inches) from the floor. Based on interview at the time of observation, the Administrator acknowledged the aforementioned portable fire extinguisher was installed on the wall more than 60 inches from the top of the extinguisher to the floor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care</p>			

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	<p>Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 34 residents, staff and visitors in the vicinity of the Oxygen Storage and Transfilling Room by the northeast nurse's station.</p> <p>Findings include:</p> <p>Based on observation with the Administrator, Maintenance Director and Housekeeping Manager during a tour of the facility from 11:25 a.m. to 12:50 p.m. on 07/12/16, one of four 'E' type oxygen cylinders was laying on the floor of the Oxygen Storage and Transfilling Room by the northeast nurse's station and was not properly chained or supported in a</p>	K 0076	<p>K 076 NFPA 101 Life Safety Code Standard</p> <p>It is the intent of this facility to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99, standard for health care facilities.</p> <p>A. ACTIONS TAKEN: 1 All facility oxygen cylinders have been inspected and are properly supported in a proper cylinder stand.</p> <p>B. OTHERS IDENTIFIED: 1 No residents were affected</p> <p>C. MEASURES TAKEN: 1 A 100 percent audit of the facilities oxygen cylinders have been audited to ensure that all oxygen cylinders have been inspected and are properly supported in a proper cylinder stand/cart. No additional findings. The Maintenance director/designee will complete a monthly audit on all oxygen cylinders as a part of the monthly preventative maintenance program and any issues will be immediately</p>	07/29/2016

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K 0130 SS=E Bldg. 01	<p>proper cylinder stand or cart. Based on interview at the time of observation, the Administrator had a cylinder cart moved by facility staff at the time of the survey to the aforementioned room to support the cylinder during storage but acknowledged one of four 'E' type oxygen cylinders in the Oxygen Storage and Transfilling Room by the northeast nurse's station had not been chained or supported in a proper cylinder stand or cart.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure.</p>	K 0130	<p>addressed.</p> <p>D. HOW MONITORED 1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing</p> <p>K 130 NFPA 101 Life Safety Code Standard</p> <p>It is the intent of this facility to ensure that rolling doors are in accordance with NFPA 80.</p> <p>A. ACTIONS TAKEN: 1 All facility rolling doors have been inspected to ensure proper operation and full closure by garage doors of Indianapolis on 7/13/16.</p> <p>B. OTHERS IDENTIFIED: 1 No residents were affected</p> <p>C. MEASURES TAKEN: 1 A 100 percent audit of the facilities rolling doors have been</p>	07/29/2016

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	<p>Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 20 residents, staff and visitors in the East Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director and Housekeeping Manager from 9:10 a.m. to 11:25 a.m. on 07/12/16, documentation of the inspection and testing of facility rolling fire doors within the most recent twelve month period was not available for review. Based on observations with the Administrator, Maintenance Director and Housekeeping Manager during a tour of the facility from 11:25 a.m. to 12:50 p.m. on 07/12/16, two rolling fire doors were noted in the kitchen protecting the openings from the kitchen to the East Dining Room. Garage Doors of Indianapolis had affixed an inspection and testing sticker to each rolling fire door which was dated 05/19/15. Based on interview at the time of the observations, the Administrator stated additional inspection and testing documentation was not available for review and acknowledged documentation</p>		<p>inspected. No additional findings. The Maintenance director/designee will complete a monthly audit on all rolling doors and ensure annual inspection is complete as a part of the monthly preventative maintenance program and any issues will be immediately addressed.</p> <p>D. HOW MONITORED 1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing</p>	

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K 0144 SS=F Bldg. 01	<p>of the inspection and testing of facility rolling fire doors within the most recent twelve month period was not available for review.</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 ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 9 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</p>	K 0144	<p>K144 NFPA 101 Life Safety Code Standard</p> <p>It is this facilities intent that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA99.</p> <p>A. ACTIONS TAKEN:</p> <p>1. Weekly generator test and monthly load test will be completed by maintenance director/designee and documented.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1. No residents were affected.</p> <p>C. MEASURES TAKEN:</p> <p>1. Weekly generator test and monthly load test will be completed</p>	07/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/12/2016	
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222			
(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>maintained and available 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 Inspection Checklist" documentation with the Maintenance Director and Housekeeping Manager during record review from 9:10 a.m. to 11:25 a.m. on 07/12/16, documentation of weekly inspections of the starting batteries for the emergency generator for the nine week period of 04/08/16 through 05/06/16 and 05/20/16 through 06/10/16 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the aforementioned nine week period was not available for review.</p> <p>3.1-19(b)</p>		<p>by maintenance director/designee. Appropriate documentation will be maintained.</p> <p>D. HOW MONITORED:</p> <p>1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing.</p>				