

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/16/2013
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NAME OF PROVIDER OR SUPPLIER  WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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(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
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K010000	<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: 07/16/13</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westminster 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. There is no fire separation between the original building and the new Rehabilitation Gym because the original</p>	K010000	<p>This alleged deficiency did not have any affect on any residents. A fire sprinkler head was installed on 8/5/13 by the Fire Sprinkler Contractor.</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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	<p>building and Rehabilitation Gym are of the same construction type. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 99 and had a census of 81 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the kitchen mop closet room.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/18/13.</p>			

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 20 residents who reside on the 100 Short Hall.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 at 1:50 p.m. during a test of the fire alarm system with the director of maintenance, the 100 Short Hall set of smoke barrier doors did not close completely, leaving a three inch gap where the doors came together. This</p>	K010027	This alleged deficiency did not have any affect on any residents that lived on the 100 short hall. All smoke barrier doors were inspected by maintenance on day of survey to assure proper operation/closing. The smoke barrier door was repaired on the day of survey to operate properly.All smoke barrier doors will be audited weekly for three months and monthly thereafter by the Maintenance Director/designee. The Administrator will audit monthly for compliance.This will be reported to the QA Committee monthly by the Maintenance Director/designee with a threshold of 100% compliance. All maintenance staff will be inserviced on smoke door compliance by 8/15/13. This will be completed by August 15, 2013.	08/15/2013			

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	<p>was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>				

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K010029 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 2 laundry room doors, which was a hazardous area laundry room over 100 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice does not affect any healthcare residents because the laundry room is located in the basement under the residential portion of the facility and separated by a 2 hour fire wall and a three hour concrete deck.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 at 11:30 a.m. with the director of maintenance, the residential building four hundred seventy five square foot basement laundry room, where laundry services are provided for the healthcare</p>	K010029	The alleged deficiency did not have any affect on any residents. The corridor door to the laundry room was provided with a self closing device which will allow the door to automatically close and to latch into the door frame. This automatic closure device was installed on 7/17/13.	08/15/2013			

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	<p>portion of the facility, had a door leading from the laundry room into the Service Hall near the Service Hall elevator which lacked a self closing device. This was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K010038 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 healthcare exit doors in the original healthcare portion of the facility electromagnetic lock remained unlocked while the fire alarm was activated and silenced. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could affect 62 residents who use the main dining room and could use the Staff Hall exit door during an evacuation.</p> <p>Findings include:</p> <p>Based on observation during a test of the</p>	K010038	<p>This alleged deficiency did not have any affect on any residents. All exit doors were inspected by maintenance on the day of survey to assure proper operation. This electromagnetic lock on the west door is now operating properly. All exit doors will be audited monthly by the Maintenance Director/designee and documented. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report findings monthly at the QA meetings with a threshold of 100% compliance. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>	08/15/2013			

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	<p>fire alarm system on 07/16/13 with the director of maintenance at 1:50 p.m., the electromagnetic lock on the Staff Hall exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K010046 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 6 of 6 battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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 any residents during periods of power outages.</p> <p>Findings include:</p> <p>Based on record review on 07/16/13 at 11:25 a.m. with the director of maintenance, the Emergency Light for Healthcare Log was reviewed and</p>	K010046	<p>This alleged deficiency did not have any affect on any residents. The six battery back up lights located in the four resident corridors in the healthcare portion of the facility will be tested annually using a 90 minute test. This annual test will be added to the Preventative Maintenance Log Book by the Maintenance Director/designee to ensure compliance. The Maintenance Director/designee will report to the QA Committee the results of the annual test when completed with the threshold being 100% compliance. The Maintenance Director/designee will audit the Healthcare Preventative Maintenance Log book monthly to ensure compliance and this will be reported to the monthly QA meeting with threshold of compliance being 100%. The Administrator will audit monthly for compliance. All maintenance staff to be inserviced by 8/15/13 to ensure compliance. This will be completed by August 15, 2013.</p>	08/15/2013			

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	<p>indicated a weekly test for each of the six battery backup lights located in the four resident corridors in the healthcare portion of the facility but failed to indicate an annual ninety minute test was conducted over the past year. The lack of an annual ninety minute test for each of the six battery backup lights was verified by the director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Periodic Fire Alarm Inspection &amp; Testing Reports on 07/16/13 at 10:00 a.m. with the director of maintenance, the most recent fire alarm system annual inspection was dated 04/09/12, which was a period exceeding one year. Based on an interview with the director of</p>	K010052	<p>1. This alleged deficiency did not have any affect on any residents. Tha annual Fire Alarm Inspection was conducted on 7/25/13 by Dallmans Systems. This annual Fire Alarm System test will be placed on a Preventative Maintenance Schedule by the Maintenance Director/designee to assure compliance. The Maintenance Director/designee will audit monthly the Healthcare Preventative Maintenance Log Book to assure compliance. The Administrator will audit monthlyfor compliance. This will be reported to the QA Committee monthly by the Maintenance Director/designee. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.2. This alleged deficiency did not have any affect on any residents. The Fire Alarm System will be tested monthly to include the transmission of the fire alarm signal by maintenance staff. Testing will be conducted the following day when simulated fire drills are utilized and documented by the Maintenance Director/designee. The</p>	08/15/2013			

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	<p>maintenance on 07/16/13 at 11:10 a.m., after the director of maintenance spoke to the fire alarm system inspection company on the telephone, it was indicated the fire alarm system inspection company postponed the annual fire alarm system inspection this year because the facility experienced a fire in the residential portion of the facility and the fire alarm system company made numerous visits over the past three months for repair work. The lack of an annual fire alarm system inspection was verified by the director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure the fire alarm system was tested to include the transmission of the fire alarm signal during 5 of 12 fire drills and 2 of 4 shifts conducted over the past year. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station Fire Alarm Systems receivers. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p>		<p>Administrator will audit monthly for compliance. This will be audited by the Maintenance Director/designee monthly and will be reported to the monthly QA Committee meeting with a threshold of 100%. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>				

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	<p>Based on review of Record of Fire Drill Reports with the director of maintenance on 07/16/13 at 10:25 a.m., the fire drills conducted on 06/26/13 at 1:40 a.m., 05/30/13 at 8:00 p.m., 03/26/13 at 1:30 a.m., 12/19/12 at 1:00 a.m. and 09/26/12 at 2:23 a.m. each indicated the drills were a simulated alarm drill written in the remarks section of each report. Based on an interview with the director of maintenance on 07/16/13 at 10:55 a.m., the simulated alarm written on each Record of Fire Drill Report indicates the fire alarm system was not tested during these fire drills and there was no follow up action after each drill was conducted to test the fire alarm system. The lack of fire alarm system transmission documentation during the above listed Record of Fire Drill Reports was verified by the director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K010056 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 rooms in the kitchen were sprinklered. This deficient practice does not affect any healthcare residents because the kitchen is located in the basement under the residential portion of the facility and separated by a 2 hour fire wall and a three hour concrete deck.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 at 11:55 a.m. with the director of maintenance, the kitchen mop closet room was not provided with sprinkler coverage. This was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00</p>	K010056	This alleged deficiency did not have any affect on any residents. A fire sprinkler head was installed to the kitchen mop closet on 8/5/13.	08/15/2013

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(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			
K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 4 of 4 sprinkler system gauges were replaced or recalibrated every 5 years. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on a review of sprinkler system inspection records on 07/16/13 at 10:00 a.m. with the director of maintenance, there was no record the sprinkler system gauges had been replaced over the past five years. Based on observation of the sprinkler riser on 07/16/13 at 12:45 p.m. with the director of maintenance, there were four gauges on the sprinkler riser with no date of manufacturer on any gauge. The lack of the four sprinkler system gauges being replaced every five</p>	K010062	<p>1. This alleged deficiency did not have any affect on any residents. Spare sidewall quick response liquid filled sprinklers and pendant quick response sprinklers have been obtained and located inside a cabinet, which is located in the healthcare center mechanical room. Maintenance Director/designee will monitor inventory of sprinkler heads monthly to assure spare heads are on hand at all times. Spare heads will be ordered in the future as needed by the Maintenance Director/designee. The Maintenance Director/designee will report the results of the audit monthly at the QA meetings with a threshold of 100%. The Administrator will audit monthly for compliance. All maintenance staff will be inserviced by 8/5/13. This will be completed by August 15, 2013.2. The alleged deficiency did not have any affect on any residents. The 4 sprinkler system gauges have been replaced with a date now stamped on each gauge. The sprinkler gauges will be placed in the Preventative Maintenance Log book to be tested and/or replaced every 5 years by the sprinkler contractor. The Maintenance</p>	08/15/2013			

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	<p>years was verified by the director of maintenance at the time of observation of the sprinkler system riser and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 4 of 12 sprinklers covered in green corrosion in the kitchen. 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 shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice does not affect any healthcare residents because the kitchen located in the basement under the residential portion of the facility and separated by a 2 hour fire wall and a three hour concrete deck.</p> <p>Findings include:</p> <p>Based on observations on 07/16/13 during a tour of the kitchen from 11:50 a.m. to 12:25 p.m. with the director of maintenance, the four sprinkler heads in the kitchen near the exit door leading into</p>		<p>Director/designee will audit the Preventative Maintenance Log monthly to assure gauges have been tested/replaced every 5 years. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report the results of the audit at monthly QA meetings with a threshold of 100%. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.3. This alleged deficiency did not have any affect on any resident. The 4 sprinkler heads in the kitchen area mentioned will be replaced by the Sprinkler Contractor. Sprinkler heads in the dietary department will be placed on a monthly audit by the Maintenance Director/designee and documented. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report findings monthly at the QA meetings with 100% threshold. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>		

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	<p>the southeast Service Hall were completely covered in green corrosion. This was verified by the director of maintenance at the time of observations and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to exercise the generator for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. 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. 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:</p> <p>a. Under operating temperature conditions or at not less than 30 percent 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.</p>	K010144	<p>This alleged deficiency did not have any affect on any residents. The generator will be excersised monthly, for a minimum of 30 minutes, and the percentage of load, which will be at least 30 percent of the EPS name plate rating or a loading that maintains a minimum exhaust gas temperature as recommended by the manufacturer. The generator contractor is working with working out our options of the 2 methods and this will be completed within the next 30 days. The generator contractor has scheduled a load bank test for this generator to be completed by 8/15/13, which will be documented. This will be audited monthly by the Maintenance Director/designee to be sure the testing is completed correctly and properly documented. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report the monthly audits to the QA Committee monthly with a threshold of 100%. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>	08/15/2013

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	<p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Healthcare Generator Set Test Log with the director of maintenance on 07/16/13 at 11:30 a.m., the monthly load test reports dating from 07/12/12 through 06/06/13 failed to indicate a percent of load or exhaust gas temperatures on each monthly load test report. The monthly load tests reports indicated amperage and voltage for each of the three branches of power. The lack of a percent of load listed on the monthly load test reports was verified by the director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K010211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul> <p>Based on observation and interview, the facility failed to ensure 2 of 4 corridor alcohol based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 28 residents who reside on the 100 Long Hall and 20 residents who reside on the 200 Short Hall.</p> <p>Findings include:</p> <p>Based on observations with the director of maintenance on 07/16/13 during a tour of the 100 Long Hall and 200 Short Hall</p>	K010211	<p>This alleged deficiency did not have any affect on the 28 residents who reside on the 100 Long Hall and 20 residents who reside on the 200 Short Hall. The two alcohol based hand sanitizer dispensers will be relocated so they will not be directly above an electrical outlet. All maintenance staff will be inserviced 8/15/13 on proper placement of alcohol sanitizer dispensers. The Maintenance Director/designee will audit dispenser locations for 3 months or until a threshold of 100% compliance is obtained for 3 consecutive months and will report finds monthly to QA Committee. The Administrator will audit monthly for compliance. This will be completed by 8/15/13.</p>	08/15/2013			

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	<p>from 12:30 p.m. to 1:55 p.m., a sixteen ounce alcohol based hand sanitizer was located next to each smoke barrier door and mounted directly above an electrical outlet. This was verified by the director of maintenance at the time of observations and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>				

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K020000	<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: 07/16/13</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westminster 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) and 410 IAC 16.2. The 2009 Rehabilitation Gym was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2009 addition to the 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 Rehabilitation</p>			K020000	<p>This alleged deficiency did not have any affect on any residents. A fire sprinkler head was installed on 8/5/13 by the Fire Sprinkler Contractor.</p>		

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	<p>Gym and connecting corridors. The facility has a capacity of 99 and had a census of 81 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except the kitchen mop closet room.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/18/13.</p>			

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K020029 SS=A	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 2 laundry room doors, which was a hazardous area laundry room over 100 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice does not affect any healthcare residents because the laundry room is located in the basement under the residential portion of the facility and separated by a 2 hour fire wall and a three hour concrete deck.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 at 11:30 a.m. with the director of maintenance, the residential building four hundred seventy five square foot basement laundry room, where laundry services are provided for the healthcare portion of the facility, had a door leading from the laundry room into the Service Hall near the Service Hall elevator which lacked a self closing device. This was verified by the director of maintenance at</p>	K020029	The alleged deficiency did not have any affect on any residents. The corridor door to the laundry room was provided with a self closing device which will allow the door to automatically close and to latch into the door frame. This automatic closure device was installed on 7/17/13.	08/15/2013			

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	<p>the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>				

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K020038 SS=E	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 Rehabilitation Gym exit door electromagnetic lock in the 2009 Rehabilitation Gym addition remained unlocked while the fire alarm was activated and silenced. LSC 18.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice could any residents who use the Rehabilitation Gym West exit as a secondary exit during an evacuation.</p> <p>Findings include:</p> <p>Based on observation during a test of the</p>	K020038	<p>This alleged deficiency did not have any affect on any residents. All exit doors were inspected by maintenance on the day of survey to assure proper operation. This electromagnetic lock on the west door is now operating properly. All exit doors will be audited monthly by the Maintenance Director/designee and documented. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report findings monthly at the QA meetings with a threshold of 100% compliance. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>	08/15/2013			

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	<p>fire alarm system on 07/16/13 with the director of maintenance at 1:50 p.m., the electromagnetic lock on the Rehabilitation Gym West exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K020052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors in the Rehab Gym.</p> <p>Findings include:</p> <p>Based on review of the facility's Periodic Fire Alarm Inspection &amp; Testing Reports on 07/16/13 at 10:00 a.m. with the director of maintenance, the most recent fire alarm system annual inspection was dated 04/09/12, which was a period exceeding one year. Based on an</p>	K020052	<p>1. This alleged deficiency did not have any affect on any residents. Tha annual Fire Alarm Inspection was conducted on 7/25/13 by Dallmans Systems. This annual Fire Alarm System test will be placed on a Preventative Maintenance Schedule by the Maintenance Director/designee to assure compliance. The Maintenance Director/designee will audit monthly the Healthcare Preventative Maintenance Log Book to assure compliance. The Administrator will audit monthlyfor compliance. This will be reported to the QA Committee monthly by the Maintenance Director/designee. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.2. This alleged deficiency did not have any affect on any residents. The Fire Alarm System will be tested monthly to include the transmission of the fire alarm signal by maintenance staff. Testing will be conducted the following day when simulated fire drills are utilized and documented by the Maintenance Director/designee. The</p>	08/15/2013			

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	<p>interview with the director of maintenance on 07/16/13 at 11:10 a.m., after the director of maintenance spoke to the fire alarm system inspection company on the telephone, it was indicated the fire alarm system inspection company postponed the annual fire alarm system inspection this year because the facility experienced a fire in the residential portion of the facility and the fire alarm system company made numerous visits over the past three months for repair work. The lack of an annual fire alarm system inspection was verified by the director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure the fire alarm system was tested to include the transmission of the fire alarm signal during 5 of 12 fire drills and 2 of 4 shifts conducted over the past year. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station Fire Alarm Systems receivers. This deficient practice could affect all residents in the facility who use the Rehab Gym.</p>		<p>Administrator will audit monthly for compliance. This will be audited by the Maintenance Director/designee monthly and will be reported to the monthly QA Committee meeting with a threshold of 100%. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>		

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	<p>Findings include:</p> <p>Based on review of Record of Fire Drill Reports with the director of maintenance on 07/16/13 at 10:25 a.m., the fire drills conducted on 06/26/13 at 1:40 a.m., 05/30/13 at 8:00 p.m., 03/26/13 at 1:30 a.m., 12/19/12 at 1:00 a.m. and 09/26/12 at 2:23 a.m. each indicated the drills were a simulated alarm drill written in the remarks section of each report. Based on an interview with the director of maintenance on 07/16/13 at 10:55 a.m., the simulated alarm written on each Record of Fire Drill Report indicates the fire alarm system was not tested during these fire drills and there was no follow up action after each drill was conducted to test the fire alarm system. The lack of fire alarm system transmission documentation during the above listed Record of Fire Drill Reports was verified by the director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>						

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K020056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 rooms in the kitchen were sprinklered. This deficient practice does not affect any healthcare residents because the kitchen is located in the basement under the residential portion of the facility and separated by a 2 hour fire wall and a three hour concrete deck.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 at 11:55 a.m. with the director of maintenance, the kitchen mop closet room was not provided with sprinkler coverage. This was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00</p>	K020056	This alleged deficiency did not have any affect on any residents. A fire sprinkler head was installed to the kitchen mop closet on 8/5/13.	08/15/2013

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K020062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in the 2009 Rehabilitation Gym in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents who use the Rehabilitation Gym if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observations on 07/16/13 during a tour of the 2009 addition Rehabilitation</p>	K020062	<p>1. This alleged deficiency did not have any affect on any residents. Spare sidewall quick response liquid filled sprinklers and pendant quick response sprinklers have been obtained and located inside a cabinet, which is located in the healthcare center mechanical room. Maintenance Director/designee will monitor inventory of sprinkler heads monthly to assure spare heads are on hand at all times. Spare heads will be ordered in the future as needed by the Maintenance Director/designee. The Maintenance Director/designee will report the results of the audit monthly at the QA meetings with a threshold of 100%. The Administrator will audit monthly for compliance. All maintenance staff will be inserviced by 8/5/13. This will be completed by August 15, 2013.2. The alleged deficiency did not have any affect on any residents. The 4 sprinkler system gauges have been replaced with a date now stamped on each gauge. The sprinkler gauges will be placed in the Preventative Maintenance Log book to be tested and/or replaced every 5 years by the sprinkler contractor. The Maintenance</p>	08/15/2013			

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	<p>Gym from 12:15 p.m. to 12:40 p.m. with the director of maintenance, there were sidewall quick response liquid filled sprinklers and pendant quick response sprinklers throughout the Rehabilitation Gym. Based on observation of the spare sprinkler cabinet with the director of maintenance on 07/16/13 at 12:45 p.m., which was located in the health care center mechanical room, there were no spare sidewall quick response liquid filled sprinklers nor pendant quick response sprinklers in the spare sprinkler cabinet. This was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview, the facility failed to ensure 4 of 4 sprinkler system gauges were replaced or recalibrated every 5 years. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents on the 2009 addition</p>		<p>Director/designee will audit the Preventative Maintenance Log monthly to assure gauges have been tested/replaced every 5 years. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report the results of the audit at monthly QA meetings with a threshold of 100%. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.3. This alleged deficiency did not have any affect on any resident. The 4 sprinkler heads in the kitchen area mentioned will be replaced by the Sprinkler Contractor. Sprinkler heads in the dietary department will be placed on a monthly audit by the Maintenance Director/designee and documented. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report findings monthly at the QA meetings with 100% threshold. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>				

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	<p>Rehabilitation Gym.</p> <p>Findings include:</p> <p>Based on a review of sprinkler system inspection records on 07/16/13 at 10:00 a.m. with the director of maintenance, there was no record the sprinkler system gauges had been replaced over the past five years. Based on observation of the sprinkler riser on 07/16/13 at 12:45 p.m. with the director of maintenance, there were four gauges on the sprinkler riser with no date of manufacturer on any gauge. The lack of the four sprinkler system gauges being replaced every five years was verified by the director of maintenance at the time of observation of the sprinkler system riser and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to replace 4 of 12 sprinklers covered in green corrosion in the kitchen. 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.</p>			
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	<p>NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice does not affect any healthcare residents because the kitchen is located in the basement under the residential portion of the facility and separated by a 2 hour fire wall and a three hour concrete deck.</p> <p>Findings include:</p> <p>Based on observations on 07/16/13 during a tour of the kitchen from 11:50 a.m. to 12:25 p.m. with the director of maintenance, the four sprinkler in the kitchen near the exit door leading into the southeast Service Hall were completely covered in green corrosion. This was verified by the director of maintenance at the time of observations and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			

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K020144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to exercise the generator for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. 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. 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:</p> <p>a. Under operating temperature conditions or at not less than 30 percent 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.</p>	K020144	<p>This alleged deficiency did not have any affect on any residents. The generator will be excersised monthly, for a minimum of 30 minutes, and the percentage of load, which will be at least 30 percent of the EPS name plate rating or a loading that maintains a minimum exhaust gas temperature as recommended by the manufacturer. The generator contractor is working with working out our options of the 2 methods and this will be completed within the next 30 days. The generator contractor has scheduled a load bank test for this generator to be completed by 8/15/13, which will be documented. This will be audited monthly by the Maintenance Director/designee to be sure the testing is completed correctly and properly documented. The Administrator will audit monthly for compliance. The Maintenance Director/designee will report the monthly audits to the QA Committee monthly with a threshold of 100%. All maintenance staff will be inserviced by 8/15/13. This will be completed by August 15, 2013.</p>	08/15/2013

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	<p>This deficient practice could affect all residents who use the 2009 addition Rehabilitation Gym.</p> <p>Findings include:</p> <p>Based on a review of the Healthcare Generator Set Test Log with the director of maintenance on 07/16/13 at 11:30 a.m., the monthly load test reports dating from 07/12/12 through 06/06/13 failed to indicate a percent of load or exhaust gas temperatures on each monthly load test report. The monthly load tests reports indicated amperage and voltage for each of the three branches of power. The lack of a percent of load listed on the monthly load test reports was verified by the director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 07/16/13 at 2:00 p.m.</p> <p>3.1-19(b)</p>			