

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2012
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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
K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health.</p> <p>Survey Date: 08/15/12</p> <p>Facility Number: 000100 Provider Number: 155191 AIM number: 100266130</p> <p>Surveyor: Steve Corya, Life Safety Code Specialist/IDF-IDD Surveyor Supervisor</p> <p>At this Quality Assurance Walk-thru survey, Westminster Health Care Center was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 96 and had a census of 89 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and not in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have</p>	K0000	This proposed plan of correction is being submitted as required by law. Submission of this plan of correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This plan of correction serves as our credible allegation of compliance.	

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>customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/22/12.</p>			

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K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation, record review and interview; the facility failed to install the battery operated smoke detectors according to manufacturer's recommendations. This deficient practice could affect all 89 residents.</p> <p>Findings include:</p> <p>During a tour of the facility on 08/15/12 from 12 noon to 1:00 p.m. with the maintenance director, the smoke detectors observed in all 48 resident rooms were mounted on the wall and butted up as close to the ceiling as possible. A review of the manufacturer's recommendations at 12:25 p.m. on</p>	K9999	<p>I. Corrective action for the residents found to be affected by the alleged deficient practice;It is the policy of Westminster Healthcare that a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all such areas, however, the alarms were not within 4 to 12 inches from the ceiling.II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;All residents have the potential to be affected by the alleged deficient practice. All smoke detectors that are not within 4 to 12 inches from the ceiling and mounted to a wall will be re-installed to the appropriate distance from the ceiling.III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;This was a situation wich resulted from the installation of additional smoke detectors in order to comply with rule 16-28, however, the installation did not place the smoke detectors 4 to 12 inches from the ceiling per manufacturers recommendations. The smoke detectors will be re-installed at the proper distance from the ceiling.IV. How the corrective action(s) will be monitored to ensure that the</p>	09/14/2012			

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	08/15/12 indicated that if wall mounted, the smoke detectors should be mounted four to twelve inches from the ceiling. An interview with the maintenance director during record review indicated the smoke detectors had been installed incorrectly. 3.1-19(ff)		deficient practice does not recur;All smoke detectors are placed on a weekly preventative maintenance list. Batteries and proper placement are checked by maintenance weekly. The results of the weekly checks will be reported at the monthly Quality Assurance meeting.V. By what date the systemic changes will be completed;September 14, 2012	