

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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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: 04/25/13</p> <p>Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Washington 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated</p>	K010000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Survey Review on or after 05/25/13.</p>	

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>smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 84 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility services including storage of supplies which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/02/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of over 75 corridor doors did not have an impediment to closing and latching. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, the following was noted:</p> <p>a. the corridor door to resident Room 212 would not latch into the door frame because the latching device did not protrude into the door frame.</p> <p>b. a door stop wedge was in use to prop the corridor door open for the</p>	K010018	<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"> The corridor door to resident Room 212 has been fixed so that it latches into the door frame All impediments to door closing in the facility have been removed <p>How will you identify other residents having the potential to be affected by the same deficient will be identified</p> <ul style="list-style-type: none"> All residents currently residing in the facility have the potential to be affected by the alleged deficient practice. All doors protecting corridor openings, such as resident room doors or applicable doors will be reviewed by 05/25/2013 to ensure the door latches into the door frame 	05/25/2013

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	<p>Marketing/Admission Office door and the Social Services door. Each of the aforementioned doors were equipped with self closing hinges.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the corridor door to resident Room 212 would not latch into the door frame and door stop wedges were used to prop open the aforementioned corridor doors.</p> <p>3.1-19(b)</p>		<p>when the door is closed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> All doors protecting corridor openings, such as resident room doors or applicable doors will be reviewed by 05/25/2013 to ensure the door latches into the door frame when the door is closed – overseen by Maintenance Supervisor. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A Life Safety Code Review audit tool will be utilized by the Maintenance Director monthly. The CQI Committee will review data. If 100% threshold is not achieved, an action plan will be developed. <p>Compliance date : 05/25/13</p>	

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the passage of wire or pipe through 1 of 1 ceiling barriers was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 44 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Executive Director during a tour of the facility from 12:40 p.m. to 4:30 p.m. on</p>	K010025	<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"> The one-inch diameter holes in the ceiling of the closet in Rooms 302, 306, 307, 310, 312, 316 and the Central Supply Office closet will be repaired and firestopped by 5/25/13 by maintenance staff. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents residing in the facility have the potential to be affected by the alleged deficient practice. A building review of all rooms will be completed by 5/25//2013 to identify further concerns of smoke barriers. <p>What measures will be put into place or what systemic changes you</p>	05/25/2013			

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	<p>04/25/13, the following was noted:</p> <p>a. a one inch diameter hole in the ceiling of the closet in Rooms 302, 307, 310, 312, 316 and the Central Supply Office closet each had three cables passing through the opening into the attic which was not firestopped.</p> <p>b. a one inch diameter hole in the ceiling of the closet in Room 306 had one cable passing through the opening into the attic which was not firestopped.</p> <p>Based on interview at the time of the observation, the Maintenance Supervisor and the Executive Director acknowledged the aforementioned openings were not firestopped.</p> <p>3.1-19(b)</p>		<p>will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · When repairs or building damage occurs in the future, facility will review areas to ensure these areas are maintained to provide at least one half hour fire resistance rating. · A building review will be completed by 5/25//2013 to identify further concerns and ensure smoke barriers are being maintained to provide at least a one half hour fire resistance rating. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · A Life Safety Code Review audit tool will be utilized by the Maintenance Director monthly. The CQI Committee will review data. If 100% threshold is not achieved, an action plan will be developed. <p>Compliance date: 05/25/13</p>	

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K010029 SS=E	<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 1 of 7 doors serving hazardous areas such as the kitchen automatically close and latch into the door frame. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, the entry door to the kitchen from the Main Dining Room is equipped with a self closing device but the door did not self close and automatically latch into the door frame because the latch did not protrude into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the entry door to the kitchen from the</p>	K010029	<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"> The entry door to the kitchen from the Main Dining Room was been fixed on 4/25/13 so that the self-close door automatically latches into the door frame. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents residing in the facility have the potential to be affected by the alleged deficient practice. A facility review of doors serving areas that may be hazardous or store combustibile items has a door that latches into the frame will be completed by 5/25/13. <p>What measures will be put into place or what systemic changes you</p>	05/25/2013
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	Main Dining Room did not latch into the door frame. 3.1-19(b)		<p>will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> A facility review of door serving areas that may be hazardous or store combustible items has a door that latches into the frame will be completed by 5/25/13. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A Life Safety Code Review audit tool will be utilized by the Maintenance Director monthly. The CQI Committee will review data. If 100% threshold is not achieved, an action plan will be developed. <p>Compliance date: 05/25/13</p>		

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K010046 SS=C	<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, observation and interview; the facility failed to document annual testing of emergency lighting in accordance with LSC 7.9 for 3 of 3 battery powered lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual functional test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights - Test Log for 2012 and 2013" documentation with the Maintenance Supervisor during record review from 9:30 a.m. to 11:55 a.m. on 04/25/13, documentation of an itemized listing of annual ninety minute test for each battery powered emergency light in the facility within the most recent twelve month period was not available for</p>	K010046	<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"> Facility will document annual testing of emergency lighting for 3 of 3 battery powered lights for not less than 1.5 hour duration. Written records of visual inspections and tests shall be kept in an itemized list. An annual test will be performed by 5/25/13 on the battery powered emergency light installed in the Maintenance Office, outside the building at the emergency generator location and in the corridor in the Alzheimer's wing. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents residing in the facility have the potential to be affected by the alleged deficient practice. Facility will document annual testing of emergency lighting for 3 of 3 battery powered lights for not less than 1.5 hour duration. Written records of visual inspections and tests shall be kept in an itemized list. <p>What measures will be put into place or what systemic changes you will make to ensure that the</p>	05/25/2013

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	<p>review. The aforementioned documentation stated "Tested all exit lights" as the results of April 2012 annual ninety minute testing. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, a battery powered emergency light was observed installed in the Maintenance Office, outside the building at the emergency generator location and in the corridor in the Alzheimer's wing. Based on interview at the time of record review and of the observations, the Maintenance Supervisor and acknowledged documentation of an annual ninety minute test within the most recent twelve month period for each battery powered emergency light in the facility was not available for review.</p> <p>3.1-19(b)</p>		<p>deficient practice does not recur</p> <ul style="list-style-type: none"> Facility will document annual testing of emergency lighting for all battery powered lights for not less than 1.5 hour duration. Written records of visual inspections and tests shall be kept in an itemized list. An annual test will be performed by 5/25/13 on the battery powered emergency lights installed in the facility. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> Preventive Maintenance tool will be completed monthly and be reviewed by Executive Director monthly. <p>Compliance date: 05/25/13</p>	

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K010062 SS=E	<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 observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Executive Director during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, the sprinkler head in the closet for resident sleeping Room 302 had a missing escutcheon plate which left a two inch opening in the ceiling into the attic. Based on interview at the time of observation, the Maintenance Supervisor and the Executive Director acknowledged the sprinkler head in the closet for resident sleeping Room 302 had a missing escutcheon plate which left a two inch opening in the ceiling into the attic.</p>	K010062	<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"> · The facility will continuously maintain sprinkler systems in reliable operating condition and ensure they are inspected and tested periodically. · The sprinkler head escutcheon in the closet for resident sleeping Room 302 will be replaced by 5/25/13. · The facility will replace the sprinkler in the bathroom for resident Room 102, which had been painted. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · The facility will continuously maintain sprinkler systems in reliable operating condition and ensure they are inspected and tested periodically. · All sprinkler heads in facility will be checked to ensure integrity of sprinkler head by Maintenance 	05/25/2013
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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 1 sprinklers in the bathroom for resident Room 102 which had been painted. 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 could affect two residents in Room 102.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, the automatic sprinkler in the bathroom for resident Room 102 had paint on the deflector. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the automatic sprinkler in the bathroom for resident Room 102 had paint on the deflector.</p>		<p>Supervisor by 5/25/13.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> The facility will continuously maintain sprinkler systems in reliable operating condition and ensure they are inspected and tested periodically. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A Life Safety Code Review audit tool will be utilized by the Maintenance Director monthly. The CQI Committee will review data. If 100% threshold is not achieved, an action plan will be developed. <p>Compliance date: 05/25/13</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013	
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231			
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K010070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 space heaters were equipped with heating elements not exceeding 212 degrees Fahrenheit (F). This deficient practice affects 20 residents, staff and visitors in the vicinity of the Payroll/Benefits Office.</p> <p>Findings include:</p> <p>Based on interview at the time of record review with the Maintenance Supervisor and Executive Director from 9:30 a.m. to 11:55 a.m. on 04/25/13, the facility does not have a written space heater policy. Based on observation with the Maintenance Supervisor and the Executive Director during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, one operable portable space heater was observed in operation in the Payroll/Benefits Office. Based on interview at the time of observation, the Executive Director acknowledged a space heater was being utilized in the Payroll/Benefits Office and</p>	K010070	<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"> Portable space heating device was removed from facility on 4/25/13. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All resident residing in the facility have the potential to be affected by the alleged deficiency. Staff will be re-educated on the prohibited use of portable space heating devices in all health care occupancies. If heating devices are in non-sleeping staff and employee areas, facility will provide documentation demonstrating the heating elements do not exceed 212 degrees Fahrenheit. Maintenance Supervisor/designee will go through facility by 5/25/13 to ensure no portable heating devices are used in facility. <p>What measures will be put into place or what systemic changes you will make to ensure that the</p>	05/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231		
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	documentation of the heating element operating temperature was not available for review. 3.1-19(b)		<p>deficient practice does not recur</p> <ul style="list-style-type: none"> Staff will be re-educated on the prohibited use of portable space heating devices in all health care occupancies. If heating devices are in non-sleeping staff and employee areas, facility will provide documentation demonstrating the heating elements do not exceed 212 degrees Fahrenheit. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> A Life Safety Code Review audit tool will be utilized by the Maintenance Director monthly. The CQI Committee will review data. If 100% threshold is not achieved, an action plan will be developed. <p>Compliance date: 05/25/13</p>		

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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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K010074 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure window curtain valences in 45 of 45 resident sleeping rooms were flame resistant. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Executive Director during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, window curtain valences were installed in all resident sleeping rooms in the facility and had no affixed documentation stating each curtain</p>	K010074	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Facility has located affixed documentation that ensures 45 of 45 window curtain valences in resident sleeping rooms are flame resistant. Resident room window curtain valence flame resistant documentation is now available for review. How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient practice. · Will maintain</p>	05/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231		
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	<p>valence was inherently flame retardant. Based on record review with the Maintenance Supervisor and the Executive Director from 9:30 a.m. to 11:55 a.m. on 04/25/13, resident room window curtain valence flame resistant documentation was not available for review. Based on interview at the time of record review and observation, the Maintenance Supervisor and the Executive Director stated the window curtain valences are not treated with a flame retardant material and acknowledged resident room window curtain valence flame resistant documentation was not available for review.</p> <p>3.1-19(b)</p>		<p>documentation on all curtain valences to ensure flame resistance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Newly introduced upholstered furniture within the facility shall meet the criteria specified in NFPA 101 Life Safety Code Standards. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · Will maintain documentation on all curtain valences to ensure flame resistance.</p> <p>Compliance date: 05/25/13</p>		

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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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K010130 SS=A	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 1 of 45 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect two residents, staff and visitors in Room 101.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for Year 2012 and 2013" documentation with the Maintenance Supervisor during record review from 9:30 a.m. to 11:55 a.m. on 04/25/13, the itemized listing of the results of monthly battery operated smoke detector testing for each resident sleeping room location from April 2012 through March 2013 listed the results for the check of one smoke detector in each room. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, two battery operated smoke detectors were observed installed in resident sleeping Room 101. One battery</p>	K010130	<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"> The extra smoke detector located above the corridor door in Room 101 was removed. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents residing in the facility have the potential to be affected by the alleged deficiency. Maintenance Supervisor will ensure that the itemized listing of the battery operated smoke detectors is accurate by 5/25/13. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> Maintenance Supervisor will ensure that the itemized listing of the battery operated smoke detectors is accurate by 5/25/13. Existing life safety features will be maintained or removed, if not required by the Life Safety Code. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what</p>	05/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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	<p>operated smoke detector was installed on the ceiling and one battery operated smoke detector was installed on the wall above the corridor door. Based on interview at the time of observation and record review, the Maintenance Supervisor stated he was unaware two battery operated smoke detectors were installed in Room 101 and acknowledged documentation of monthly battery operated smoke detector testing for the wall mounted battery operated smoke detector in Room 101 was not available for review.</p> <p>3.1-19(a)</p>		<p>quality assurance program will be put into place</p> <ul style="list-style-type: none"> · Maintenance Supervisor will ensure that the itemized listing of the battery operated smoke detectors is accurate by 5/25/13. · A Life Safety Code Review audit tool will be utilized by the Maintenance Director monthly. The CQI Committee will review data. If 100% threshold is not achieved, an action plan will be developed. <p>Compliance date: 05/25/13</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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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 ensure a monthly load test for the emergency generator was conducted for 1 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</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. NFPA 99, 3-5.4.2 requires a written record of</p>	K010144	<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"> Tests are now being performed and documented showing that the emergency generator is being load tested at not less than 30% of the EPS. A 2-hour load bank test by an outside vendor is being performed on the generator annually. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> All residents residing in the facility have the potential to be affected by this alleged deficient practice. Tests are now being performed and documented showing that the emergency generator is being load tested at not less than 30% of the EPS. A 2-hour load bank test by an outside vendor is being performed on the generator annually. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> Tests are now being 	05/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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	<p>inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Supervisor during record review from 9:30 a.m. to 11:55 a.m. on 04/25/13, monthly load test documentation for July 2012 was incomplete. The July 2012 load test documentation did not include if the emergency generator ran under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation for July 2012 monthly load testing did not indicate the emergency generator ran for a minimum of 30 minutes under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as</p>		<p>performed and documented showing that the emergency generator is being load tested at not less than 30% of the EPS. A 2-hour load bank test by an outside vendor is being performed on the generator annually.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · Maintenance Supervisor/designee will conduct the weekly load generator inspections, exercising under load for 30 minutes per month and record on Emergency Generator/Load Testing log. · Executive Director will review monthly. <p>Compliance date: 05/25/13</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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	recommended by the manufacturer. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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K010147 SS=E	<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>Based on observation and interview, the facility failed to ensure 2 of 2 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 42 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Executive Director during a tour of the facility from 12:40 p.m. to 4:30 p.m. on 04/25/13, the following was noted:</p> <p>a. a refrigerator and a coffee pot were plugged into a power strip in the Maintenance Office.</p> <p>b) a refrigerator was plugged into a power strip in the Director of Nursing Services Office.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor and the Executive Director acknowledged power strips were used as a substitute for fixed wiring at the aforementioned locations.</p>	K010147	<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"> · The refrigerator and coffee pot plugged into a power strip in the Maintenance Office were removed from the power strip on 4/25/13. · The refrigerator in the Director of Nursing Services Office was removed from the power strip and the power strip. <p>How will you identify other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken</p> <ul style="list-style-type: none"> · All residents residing in the facility have the potential to be affected by the alleged deficiency. · Extension cords, including power strips, will not be used as a substitute for fixed wiring in the facility, unless specifically permitted. · Maintenance Supervisor/designee will audit facility by 5/25/13 to ensure no power strips are used for high-draw equipment. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · Staff will be re-educated on the prohibited use of extension 	05/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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	3.1-19(b)		<p>cords, including power strips, as a substitute for fixed wiring in the facility, unless specifically permitted. This will be completed by 5/25/13 by the Maintenance Supervisor/Staff Development Coordinator/designee.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>A Life Safety Code Review audit tool will be utilized by the Maintenance Director monthly. The CQI Committee will review data. If 100% threshold is not achieved, an action plan will be developed.</p> <p>Compliance date: 05/25/13</p>	