

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/23/2014	
NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706			
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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: 06/23/14</p> <p>Facility Number: 000307 Provider Number: 155666 AIM Number: 100285660</p> <p>Surveyors: Brett Overmyer, Life Safety Code Specialist and Dennis Austill, Life Safety Code Specialist.</p> <p>At this Life Safety Code survey, Wesley Healthcare and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in areas open</p>	K010000	<p>This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the state allegations. Wesley Healthcare and Rehabilitation Center LLC maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare and Rehabilitation Center further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare and Rehabilitation LLC requests paper compliance for K027, K029, K062, K066, K067, K147. These were found to be low severity. There was no actual citation of harm to any of the residents.</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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K010027 SS=E	<p>to the corridors and in resident rooms. The facility has a capacity of 69 and had a census of 46 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/26/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 3 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect at least 10 residents, staff and visitors.</p> <p>Findings include:</p>	K010027	The West door and the 200 hall South has been repaired by A 1 Door Specialty Inc. Enclosed is the repair report from A 1 Door Specialty. The maintenance man will check the doors monthly to ensure that the deficient practice will not reoccur, the administrator will monitor on a quarterly basis during the QA review so that the	07/23/2014			

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K010029 SS=E	<p>Based on observation with the Administrator at 10:30 a.m. on 06/23/14, the west door in the 200 hall (South) set of smoke barrier doors hit the door frame at the top of the door, leaving a quarter inch gap between the doors and would not close to form a smoke resistive barrier. Based on interview at the time of observation, the Administrator acknowledged the door set did not close completely because the west door of the south smoke barrier hit the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved 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 5 doors serving hazardous areas such as a kitchen closed and latched to prevent the passage of smoke. This deficient practice could</p>	K010029	<p>deficient practice will not reoccur.</p> <p>The kitchen serving door has been repaired by A 1 Door Specialty Inc. Please see enclosed invoice. Maintenance man will check on a monthly basis to ensure that a deficient practice will not reoccur, the</p>	07/23/2014

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K010062 SS=C	<p>affect at least 10 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 06/23/14 at 10:45 a.m., the kitchen serving door self closed when released from the magnetic hold open device but did not latch into the frame. Based on interview at the time of observation, the Administrator acknowledged the kitchen serving door did not latch securely into the door frame to prevent the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system's components was inspected quarterly for 3 of 4 calendar quarters. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.</p>	K010062	<p>administrator will monitor on a quarterly basis in the QA meeting to make sure that a deficient practice will not reoccur.</p> <p>Enclosed is a contract with Koorsen Fire and Security for Quarterly sprinkler inspections. The maintenance man will check to ensure that the deficient practice does not reoccur on a monthly basis and the administrator will monitor that the deficient practice does not reoccur on a quarterly basis during QA. All sprinkler heads in</p>	07/23/2014			

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	<p>NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on sprinkler system record review with the Administrator on 06/23/14 from 9:45 a.m. to 12:00 p.m., the last documented sprinkler system inspection occurred on 05/20/14 but but the facility lacked documentation of sprinkler inspections of the previous three quarters. Based on interview at the time of record review, the Administrator acknowledged there was no written documentation or other evidence the sprinkler system had been inspected the third and fourth quarter of 2013 and the first quarter of 2014.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in</p>		<p>escutcheon in the facility have been checked and cleaned and determined to be in good working order by the maintenance man. Environmental director will check on a monthly basis to ensure that the deficient practice does not reoccur. The administrator will monitor on a quarterly basis during the QA to ensure the deficient practice does not reoccur.</p>				

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	<p>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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator from 10:15 a.m. to 11:30 p.m. on 06/23/14, the following was noted:</p> <ol style="list-style-type: none"> The sprinkler head in the staff break room was dusty. The sprinkler heads in front and behind the dryers in the laundry were dusty. The sprinkler head in resident room 208 had paint on the deflector. The escutcheon was missing from the sprinkler head in the corridor outside the generator electrical room. <p>Based on interview during the times of the observations, the Administrator acknowledged the aforementioned sprinklers were dusty, the escutcheon was missing, or had paint on the deflector.</p> <p>3.1-19(b)</p>			

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K010066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review, and interview: the facility failed to enforce its smoking policy for 2 of 3 residents who smoke in the facility. This deficient practice could affect at least 2 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on an observation on 06/23/14 at</p>	K010066	Attached is a updated smoking policy and procedure for Wesley Healthcare and Rehabilitation Center LLC. All Wesley Healthcare staff have been inserviced regarding this policy. The Director of Nursing will check for compliance on a monthly basis to ensure that the deficient practice does not reoccur. The administrator will monitor on a quarterly basis during QA to ensure that the deficient practice	07/23/2014

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K010067 SS=F	<p>9:30 a.m., there were two residents smoking on the front porch area with no supervision. Based on record review from 9:45 a.m. to 12:00 p.m. with the Administrator, the smoking policy stated a staff member or a family member shall be present during the smoke break. Based on interview at the time of record review, the Administrator acknowledged the aforementioned condition and policy.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 30 of 30 fire dampers throughout the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least</p>	K010067	<p>does not reoccur.- The policy has been revised to indicate the designated area for residents to smoke and to include that staff can not smoke on Wesley Healthcare property.</p> <p>Enclosed is a contract from Koorsen Fire and Security to inspect and repair all HVAC supply and return air vents throughout the facility. The maintenance man will check on a monthly basis to ensure that the deficient practice does not reoccur. The administrator will monitor on a quarterly basis during QA to ensure that the deficient practice does not reoccur.</p>	07/23/2014

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K010147 SS=E	<p>every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator from 10:15 a.m. to 11:30 a.m. on 06/23/14, the facility had at least 30 fire dampers located in the HVAC supply and return air vents throughout the facility. Based on interview during the time of observation, the Administrator acknowledged there was no documentation regarding fire damper inspection and service within the past four years.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 7 of 7 pieces of medical equipment and high current draw</p>	K010147	The facility added over 100 outlets and has removed all power strip cords from the facility.	07/23/2014			

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	<p>electrical devices were not plugged into powers strips or extension cords as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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 at least 20 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator from 10:15 a.m. to 11:30 a.m. during a tour of the facility on 06/23/14, the following was noted:</p> <ol style="list-style-type: none"> A microwave was plugged into a power strip in resident room 115. Medical pumps were plugged into a power strip in resident room 108. A refrigerator and a microwave oven were plugged into a power strip in the staff break room. A nebulizer was plugged into a power strip in resident room 208. Medical pumps were plugged into a power strip in resident room 203. A refrigerator was plugged into a power strip in resident room 201. Medical pumps were plugged into a 		<p>All medical equipment, refrigerators, microwaves are plugged directly into a wall outlet. The maintenance man will check on a monthly basis to ensure that the deficient practice does not reoccur. The Environmental Director will monitor on a quarterly basis to ensure that the deficient practice does not reoccur.</p>		

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	power strip in resident room 304. Based on interview at the times of observation, the Administrator acknowledged the aforementioned conditions. 3.1-19(b)				