

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155389	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/16/2013
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NAME OF PROVIDER OR SUPPLIER WESTPARK HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222
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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: 04/16/13</p> <p>Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westpark Healthcare 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 consisted of two sections: the original section determined to be Type III (200) construction and the Addition was determined to be Type V (000) construction. The facility is fully sprinklered except for the copy room. The facility has a fire alarm system with</p>	K010000		
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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>smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The entire facility was surveyed as Type V (000) construction. The facility has a capacity of 89 and had a census of 45 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. The facility has two detached storage sheds which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/18/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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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>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 28 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Assistant Administrator during a tour of the facility from 12:10 p.m. to 3:15 p.m. on 04/16/13, a four inch in diameter hole in the ceiling of the Electrical Equipment Room had eight cables passing through the opening which was not firestopped. Based on interview at the time of observation, the Maintenance Supervisor and the Assistant Administrator acknowledged the aforementioned opening was not firestopped.</p>	K010025	(1) The four inch hole was closed with appropriate dry wall and fire caulk on 5/6/13. (2) The twelve inch, the eight inch, and the four inch hole has been closed with appropriate dry wall and fire caulk. The maintenance supervisor will ensure that maintenance contractors will not breach any fire walls without making the necessary repairs.	05/06/2013	

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the passage of wire or pipe through 1 of 4 smoke barrier walls in the southwest Equipment Room and in the Electrical Equipment Room were 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 28 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Assistant Administrator during a tour of the facility from 12:10 p.m. to 3:15 p.m. on 04/16/13, a four inch by three inch rectangular shaped cutout in the wall of the southwest Equipment Room had one computer cable passing through the opening which was not firestopped. In addition, a twelve by ten inch hole, an eight by two inch hole and a four by four inch hole were cut into</p>						

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	<p>the wall above three electrical panels which were not firestopped in the Electrical Equipment Room. Based on interview at the time of observation, the Maintenance Supervisor and the Assistant Administrator acknowledged the aforementioned openings were not firestopped.</p> <p>3.1-19(b)</p>			

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K010050 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 4 of 4 quarters. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Supervisor during record review from 9:05 a.m. to 11:30 a.m. on 04/16/13, first shift fire drills conducted on 04/19/12, 07/26/12, 10/15/12 and 01/11/13 were conducted, respectively, at 7:30 a.m., 8:00 a.m., 7:30 a.m. and 7:30 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged first shift fire drills were not conducted at unexpected times under varying conditions.</p>	K010050	The maintenance supervisor will conduct all future fire drills at varying times. The administrator will review fire drill report forms to ensure compliance.	05/16/2013			

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K010052 SS=C	<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>Based on observation and interview, the facility failed to maintain 7 of 88 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.4.3 states ceiling mounted smoke detectors shall be located not less than 4 inches from a sidewall to the nearest edge. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. 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 Assistant Administrator during a tour of the facility from 12:10 p.m. to 3:15 p.m. on 04/16/13, the following smoke detector locations were each less than four inches from a sidewall or less than three feet from an air supply or return vent:</p>	K010052	The smoke detectors noted at a, b, and c locations on the 2567 will be moved so that they are in compliance. Smoke detectors throughout the building will be checked for compliance. All smoke detectors in the building are hard wired, including in the patient rooms. The smoke detector noted in d is a heat sensor not a smoke detector and will not be moved. The administrator will monitor for compliance.	05/16/2013			

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	<p>a. the smoke detector on the ceiling in the corridor above the cross corridor door set by Room 11 was mounted one inch from the cross corridor door set wall.</p> <p>b. the smoke detector on the ceiling in the corridor outside Room 2 was located two feet eight inches from an air supply vent.</p> <p>c. the smoke detector on the ceiling in the Progressive Wellness Therapy Center, the East Dining Room, the East Nurse's Station and in the corridor by Room 17 were each located one foot from an air supply vent.</p> <p>d. the smoke detector on the ceiling in the Beauty Shop was located one foot from an air supply vent and one foot from an air return vent.</p> <p>Based on interview at the time of the observations, the Maintenance Supervisor and the Assistant Administrator acknowledged the aforementioned smoke detector locations were installed less than four inches from a sidewall or less than three feet from an air supply or an air return vent.</p> <p>3.1-19(b)</p>			

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K010056 SS=D	<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 provide sprinkler coverage for 1 of 1 administrative area photocopy rooms. This deficient practice could affect 3 staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Assistant Administrator during a tour of the facility from 12:10 p.m. to 3:15 p.m. on 04/16/13, the administrative area photocopy room was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Supervisor and the Assistant Administrator acknowledged the administrative area photocopy room was not provided with automatic sprinklers.</p>	K010056	An automatic sprinkler head will be added to the administrative area copy room. The maintenance supervisor will oversee the installation to ensure any fire wall breaches are sealed.	05/16/2013			

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	3.1-19(b) 3.1-19(ff)			

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K010070 SS=B	<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 all residents, staff and visitors in the vicinity of Room 420.</p> <p>Findings include:</p> <p>Based on interview at the time of record review with the Maintenance Supervisor from 9:05 a.m. to 11:30 a.m. on 04/16/13, the facility has no written space heater policy. Based on observation with the Maintenance Supervisor and the Assistant Administrator during a tour of the facility from 12:10 p.m. to 3:15 p.m. on 04/16/13, one operable portable space heater was observed in the Owner's Office which is a nonsleeping staff room area. Based on interview at the time of observation, the Maintenance Supervisor and the Assistant Administrator stated documentation of the heating element operating temperature was not available for review and acknowledged a space heater was being</p>	K010070	A space heater policy has been written by the administrator. It forbids the use of space heaters in patient sleeping areas and does not allow heat elements in excess of 212 degrees. The heating element on the space heater in question has been disconnected. The maintenance supervisor will ensure compliance.	05/06/2013			

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	utilized in a nonsleeping staff room area without documentation of the heating element operating temperature. 3.1-19(b)			

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 electrical wall fixtures in the oxygen storage and transfilling room were located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect 28 residents, staff and visitors in the vicinity of the oxygen storage room and transfilling room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Assistant Administrator during a tour of the facility</p>	K010076	Both light switches and the electrical outlet have been raised to above sixty inches from the floor in the oxygen storage room. The maintenance supervisor will ensure compliance.	05/16/2013	

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	<p>from 12:10 p.m. to 3:15 p.m. on 04/16/13, the following was noted in the oxygen storage and transfilling room:</p> <p>a. one electrical outlet was located on the wall 12 inches (1 foot) above the floor.</p> <p>b. one light switch was located on the wall 44 inches (3 feet, 8 inches) above the floor and a second light switch was located on the wall 48 inches (4 feet) above the floor.</p> <p>Six liquid oxygen storage containers were observed stored in the room. Based on interview at the time of the observations, the Maintenance Supervisor and the Assistant Administrator acknowledged each of the aforementioned electrical wall fixtures were located on the wall less than five feet above the floor of the oxygen storage and transfilling room.</p> <p>3.1-19(b)</p>			

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K010130 SS=C	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 6 of 6 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Assistant Administrator during a tour of the facility from 12:10 p.m. to 3:15 p.m. on 04/16/13, each of six natural gas fired water heaters in the facility had no Certificate of Inspection documentation from the State of Indiana available for review. Two water heaters were observed in the West Equipment Room and four water heaters were observed in the Maintenance Room. Each of the waters heaters was listed as 87 gallon capacity and were manufactured in 2012. Based on interview at the time of the observations, the Maintenance Supervisor stated each water heater was installed in October 2012, was a like kind</p>	K010130	On 4/23/13 the administrator spoke with an inspector with the boiler pressure division. This call occurred at 9:00 AM. We will be placed on their inspection schedule. We will receive an email to this effect. I am requesting a 60-90 day extension for compliance with this tag because the inspector informed me that it is at least a 30-60 day process after the inspection is completed. The administrator will monitor for compliance.	07/16/2013			

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	<p>replacement water heater and acknowledged each of the aforementioned water heaters had no Certificate of Inspection from the State of Indiana available for review.</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 ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 3 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-Monthly Test Log" documentation with the Maintenance Supervisor during record review from 9:05 a.m. to 11:30 a.m. on 04/16/13, documentation of emergency power transfer time of monthly load tests for the three month period of January through</p>	K010144	The maintenance supervisor will document the transfer time of monthly load tests for each month forward beginning in April. The administrator will ensure future compliance.	05/06/2013

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	<p>March 2013 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged emergency power transfer time documentation for the aforementioned monthly load tests was not available for review.</p> <p>3.1-19(b)</p>			

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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 observations and interview, the facility failed to ensure 1 of 10 electrical junction boxes in the attic smoke compartment above the northwest corridor were contained in junction boxes with covers. NFPA 70, National Electrical Code, 1999 Edition, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 14 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:10 p.m. to 3:15 p.m. on 04/16/13, the electrical junction box mounted on the wall in the attic above the cross corridor door set by Room 7 had electrical wires jutting out of junction box without a cover. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned electrical junction box was not protected with a cover.</p> <p>3.1-19(b)</p>	K010147	The junction box cover has been replaced. The maintenance supervisor will do a monthly check on all junction boxes to ensure compliance.	05/16/2013			

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K010154 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 45 of 45 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K010154	The fire watch procedure has been altered to include notification of the fire department, the alarm company, the owner and operator of the building, and the Indiana Department of Health whenever a fire watch is initiated. The administrator will ensure compliance.	05/06/2013			

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	<p>Based on review of "Fire Watch Procedure" documentation with the Maintenance Supervisor during record review from 9:05 a.m. to 11:30 a.m. on 04/16/13, the fire watch policy did not include notification of the insurance carrier, alarm company and the building owner/manager. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire watch policy did not include notification of the aforementioned entities.</p> <p>3.1-19(b)</p>			

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K010155 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 45 of 45 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Watch Procedure" documentation with the Maintenance Supervisor during record review from 9:05 a.m. to 11:30 a.m. on 04/16/13, the fire watch policy stated a fire watch would be conducted for fire alarm system impairment "until the sprinkler system is repaired." Based on interview at the time of record review, the Maintenance Supervisor stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not</p>	K010155	The noted policy has been changed to include continuation of fire watches until both fire alarm and sprinkler system are on-line and operational. The policy notes that a failure of either system for more than 4 hours in a 24 hour period will require a documented fire watch. The administrator will ensure compliance.	05/06/2013			

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	include the policy to conduct the fire watch until the fire alarm system is repaired. 3.1-19(b)			