

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2011
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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN47802
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K0000	<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: 08/16/11</p> <p>Facility Number: 000139 Provider Number: 155234 AIM Number: 100266410</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westridge 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 (000) construction and was fully</p>	K0000	<p>Submission of this Plan of Correction does not constitute an admission to an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</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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K0021 SS=F	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 66 and had a census of 51 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/18/11.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of 4 smoke barrier door sets would remain self closing</p>	K0021	All facility fire door magnets will be rewired to ensure that magnets remain disengaged while alarm system is in silence mode. Door coordinators were	09/15/2011	

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	<p>until the fire alarm system was returned to normal operations after activation. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations made with the maintenance director and administrator on 08/16/11 at 2:35 p.m., magnets holding open all fire doors released the doors to self close upon activation of the fire alarm. When the fire alarm system was placed in the silence mode, the doors were opened and the magnetic devices designed to hold the doors open reengaged to hold the fire doors open instead of allowing them to self close until the fire alarm was reset. The maintenance director said at the time of observations he was unaware the magnets shouldn't hold the doors open until the fire system was reset.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 4 smoke barrier door sets were held open by devices</p>		<p>replace on 4 of 4 fire doors to ensure proper door closure to create proper fire barrier August 24, 2011. Facility conducts monthly fire drills on all shifts. All magnets will be checked for proper functioning during fire drills. Any issues with magnet functioning will be corrected immediately, logged and discussed during monthly Quality Assurance meeting. Maintenance Director or designee will check door coordinator functioning weekly. Any issues will be corrected immediately, logged and discussed during monthly Quality Assurance meeting.</p>		

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	<p>which would allow the doors to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 37 residents in the east and north smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director and administrator on 08/16/11 between 10:35 a.m. and 2:15 p.m., the smoke barrier door sets were equipped with door coordinators. Upon testing the coordinators on the smoke barrier door sets near room 102 and room 202, each was prevented from closing when the doors hit the door coordinators attached to the tops of the door frames. The maintenance director said at the time of observation, he had to make adjustments to the coordinators because they frequently failed to operate correctly. The maintenance director agreed at the time of observations, the coordinators were not functioning as designed when they prevented the doors from closing.</p>						

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K0025 SS=E	<p>3.1-19(b)</p> <p>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 a gap in the ceiling smoke barrier in 1 of 6 smoke compartments was protected with an approved material 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 that 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</p>	K0025	All penetrations to smoke barrier identified during survey were corrected using appropriate fire rated caulking. Corrections were completed as of August 30, 2011. Director of Maintenance toured facility to ensure all smoke barriers were intact. No other penetrations were noted at this time. Director of Maintenance or designee will check all penetrations monthly to ensure all fire barriers are intact. Any noted gaps will be corrected immediately, logged and reviewed at monthly Quality Assurance meeting.	08/30/2011	

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K0048 SS=F	<p>approved device designed for the specific purpose. This deficient could affect visitors, staff and 5 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 8/16/11 at 12:30 p.m., a two inch gap was evident around the pipe penetrating the ceiling adjacent to the kitchen range hood and based on observation with the maintenance director on 8/16/11 at 1:15 p.m., a two inch gap was unsealed in the biohazard storage room adjacent to the ceiling exhaust vent. The maintenance director said at the time of observation, he had not seen the openings.</p> <p>3.1-19(b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the evacuation of the</p>	K0048	Facility evacuation procedure was updated to include zone to zone evacuations. All staff will be inserviced on evacuation	09/15/2011	

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	<p>smoke compartment in the written fire plan for the protection of 51 of 51 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility Emergency Policy and Procedures with the maintenance director and administrator on 08/16/11 at 11:50 a.m., the evacuation plan did not address internal evacuation from one smoke compartment to another. Internal evacuation in the evacuation plan refers to evacuation to "another</p>		<p>proceedures by September 15, 2011. Evacuation procedures will be reviewed with staff during monthly fire drills.</p>		

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K0062 SS=F	<p>part of the building" rather than another smoke compartment separated by smoke barrier doors. The maintenance director said at the time of record review the evacuation and fire drill training included this procedure, but agreed it was not a part of the written record.</p> <p>3.1-19(b)</p> <p>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>Based on record review, observation and interview; the facility failed to ensure 2 of 2 automatic sprinkler system gauges were replaced or calibration tested every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 2-3.2. 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</p>	K0062	<p>Sprinkler systems gauges were replaced August 28, 2011. Director of Maintenance or designee will track gauge replacement or calibration/testing to ensure that replacement or testing occurs every five years. Facility fire prevention vendor will check gauges for functioning during their quarterly inspections.</p>	08/18/2011	

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	<p>full scale shall be recalibrated or replaced. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of sprinkler system maintenance and test reports with the maintenance director and administrator on 08/16/11 at 11:00 a.m., two sprinkler system gauges were replaced 07/25/06 The maintenance director said at the time of record review he had no record of another replacement or calibration test for sprinkler system pressure gauges since then. Dates observed on the on the sprinkler gauges at 1:50 p.m. on 08/16/11 were 07/06, indicating the last date of inspection/replacement. The maintenance director said at the time of record review, he did not know the gauges needed to be replaced or calibrated again.</p> <p>3.1-19(b)</p>				

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K0144 SS=C	<p>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 interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires weekly maintenance of the emergency generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-3.6 requires storage batteries used for generator sets in Level 1 and 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all</p>	K0144	<p>Facility's generator battery was inspected and found to be fully functioning August 17, 2011. Maintenance Director or designee will visually inspect battery weekly to ensure the battery is in good repair. A voltage reading will be taken at this time to ensure proper battery charge. Any problems identified during weekly inspections will be address immediately up to and including battery replacement. Any identified problems will be logged and discussed during monthly Quality Assurance meeting.</p>	09/15/2011			

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and review of the Emergency Generator –Weekly Inspection Checklist with the maintenance director and administrator on 08/16/11 at 11:10 a.m., documentation of weekly battery inspections for the emergency generator was not found for the past year. The maintenance director said at the time of record review, he did check the battery each month when he transferred the load but made no documentation.</p> <p>3.1–19(b)</p>				