

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  07/28/2014
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NAME OF PROVIDER OR SUPPLIER  WASHINGTON HEALTHCARE 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: 07/28/14</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</p>	K010000	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. 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 08/27/2014.	
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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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K010015 SS=E	<p>operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 82 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing for storage of supplies which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/31/14.</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 Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the</p>	K010015	What corrective action(s) will be accomplished for those residents	08/27/2014

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	<p>facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of over 50 rooms. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:35 a.m. to 2:40 p.m. on 07/28/14, all four walls of the 18 inch by 18 inch combustion air intake for fuel fired equipment in the Laundry behind the dryers had exposed wood studs. In addition, the two inch annular space surrounding an eight inch in diameter dryer vent exposed one wood stud of the attic above. Based on interview at the time of the observations, the Maintenance Director stated the exposed wood studs had not been treated with a flame retardant material and acknowledged flame spread rating documentation was not available for review for the exposed wood studs in the Laundry behind the dryers.</p> <p>3.1-19(b)</p>		<p><b>found to have been affected by the deficient practice?</b></p> <p>Exposed wood studs treated with Class A flame retardant. <b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b></p> <p>Maintenance director observed for untreated wood studs throughout facility and none were located. All residents have the potential to be affected by this alleged deficient practice.</p> <p>Exposed wood studs treated by 8/27/14.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>Maintenance Director/Designee will apply Class A flame retardant to exposed wood studs at least monthly.<b>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</b></p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</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 50 corridor doors would close, latch and resist the passage of smoke. This deficient practice could affect 44 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:35 a.m. to 2:40 p.m. on 07/28/14, the following was noted:</p> <p>a. the corridor door to the Storage Room by the East Dining Room had a one half inch in diameter hole above the door handle.</p> <p>b. the corridor door to the Nourishment Pantry by the East Dining Room had a</p>	K010018	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Holes in Storage Room, Nourishment Pantry and Kitchen door will be filled by 8/27/2014.<b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b> Maintenance director inspected all doors throughout facility to ensure integrity of doors is maintained. All residents have the potential to be affected by this alleged deficient practice. All holes to be filled by 8/27/2014. <b>What measures will be put into place or what systemic changes you will make to ensure that the</b></p>	08/27/2014

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K010025 SS=E	<p>one inch in diameter hole above the door handle.</p> <p>c. the entry door to the kitchen from the Alzheimer's wing had a one inch in diameter hole and a half inch in diameter hole above the door handle.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned corridor doors would not resist the passage of smoke for at least 20 minutes.</p> <p>3.1-19(b)</p> <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 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage</p>	K010025	<p><b>deficient practice does not recur</b> Maintenance Director/Designee will conduct rounds monthly to ensure no holes in fire rated doors.<b>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</b></p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Dry wall to be installed around vent by 8/27/14.</p>	08/27/2014

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	<p>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 22 residents, staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:35 a.m. to 2:40 p.m. on 07/28/14, the following openings were noted in the ceiling smoke barrier of the Laundry behind the dryers which failed to maintain the smoke resistance of the ceiling smoke barrier:</p> <ol style="list-style-type: none"> <li>the two inch annular space surrounding an eight inch in diameter dryer vent.</li> <li>two separate one inch in diameter holes, one of which contained the passage of a three quarter inch in diameter flexible blue water line.</li> </ol> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings failed to maintain the smoke resistance of the ceiling smoke barrier.</p>		<p>Two one-inch diameter holes filled with fire-rated caulking by 8/27/14</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b></p> <p>Maintenance director inspected all doors all ceiling smoke barriers to ensure smoke barriers are maintained.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Dry wall and holes to be filled by 8/27/2014.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>Maintenance Director/Designee will conduct rounds monthly to ensure all smoke barrier ceilings are fire resistant. <b>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</b></p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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K010029 SS=E	<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 9 hazardous areas such as fuel fired heater rooms were separated from other areas by smoke resistant partitions. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:35 a.m. to 2:40 p.m. on 07/28/14, the following openings were noted in the ceiling of the Laundry behind the natural gas fired dryers which failed to separate the Laundry from other</p>	K010029	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Dry wall to be installed around vent by 8/27/14.</p> <p>Two one-inch diameter holes filled with fire-rated caulking by 8/27/14</p> <p><b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b></p> <p>Maintenance director inspected all hazardous areas to ensure rooms are separated by smoke resistant partitions.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Dry wall and holes to be filled by</p>	08/27/2014

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K010052 SS=E	<p>areas by smoke resistant partitions: a. the two inch annular space surrounding an eight inch in diameter dryer vent. b. two separate one inch in diameter holes, one of which contained the passage of a three quarter inch in diameter flexible blue water line. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings failed to separate the aforementioned hazardous area from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to maintain 1 of 38 smoke detectors in accordance with NFPA 72, National Fire Alarm Code. NFPA 72,</p>	K010052	<p>8/27/2014.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Maintenance Director/Designee will conduct rounds monthly to ensure all hazardous rooms are separated by smoke resistant partitions.<b>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</b> To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Smoke detector to be relocated</p>	08/27/2014

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	<p>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 20 residents, staff and visitors in the vicinity of the Main Conference Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 2:40 p.m. on 07/28/14, the smoke detector in the Main Conference Room was located on the ceiling within six inches of an air supply vent. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned smoke detector was located on the ceiling within six inches of an air supply vent.</p> <p>3.1-19(b)</p>		<p>away from air supply vent by 8/27/14. <b>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</b></p> <p>All smoke detectors observed by Maintenance Director/Designee to ensure smoke detectors are at least 6 inches from air vent. All residents have the potential to be affected by this alleged deficient practice. Smoke detector to be relocated away from air supply vent by 8/27/14.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>Maintenance Director/Designee will conduct rounds monthly to ensure smoke detectors at least 6 inches from air supply vent. <b>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</b></p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

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