

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
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NAME OF PROVIDER OR SUPPLIER WESLEY MANOR HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 N MAIN ST FRANKFORT, IN 46041
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K020000	<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: 08/05/14</p> <p>Facility Number: 001152 Provider Number: 155658 AIM Number: 200221050</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Wesley Manor Health 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 18, New Health Care Occupancies and 410 IAC 16.2. The facility was surveyed under Chapter 18 due to the extensive renovation of the health care wing located in the original building identified as F and the addition of two new wings G and H in 2005.</p> <p>This facility was surveyed as two buildings because of different</p>	K020000	<p>Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor, Inc. provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents.</p> <p>As required, the facility submits the following plan of correction:</p>	
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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>construction types. The F wing, located on the ground and first floors of a four story fully sprinklered building with a basement was determined to be Type II (222) construction. G and H wings were one story, fully sprinklered and determined to be Type II (000) construction. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident rooms. The facility has a capacity of 96 and had a census of 86 at the time of this survey.</p> <p>All areas which provide customary access to residents were sprinklered. All areas which provide facility services such as the laundry, generator room, boiler room and maintenance department were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/12/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K020038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 exit doors and 2 of 2 sets of smoke doors with electromagnetic locks unlocked while the fire alarm system was activated. LSC 7.2.1.6.2(e) requires doors with special locking arrangements such as electromagnetic locks shall automatically unlock upon actuation of an approved fire alarm system and remain unlocked until the system is reset. This deficient practice could affect residents in the G and H wings as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 08/05/14 during a fire alarm test at 3:17 p.m. with the Maintenance Supervisor, the electromagnetic locks on the G and H wings' smoke barrier doors and exit doors would not unlock when the fire alarm was activated. Based on interview on</p>	K020038	<p>K038 This tag was cited due to magnetic locks on the secured memory care units not automatically unlocking when the fire alarm sounded. It appears that this problem occurred due to changes in the fire panel's programming that occurred unintentionally with routine servicing. The contractor who services the facility's fire alarm system has been contacted to reprogram the panel in order to correct this problem. In order to keep this problem from occurring again, the facility has:</p> <ol style="list-style-type: none"> 1. Amended the form used to assess fire drills (Attachment A) in order to clarify to staff who are administering the fire drills that they are required to physically push open each of the memory care unit's 4 fire exit doors in order to determine whether the magnetic locks have unlocked during activation of the fire alarm. 2. The Administrator will review the fire report after each drill to make certain that this evaluation 	09/04/2014
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K020047 SS=D	<p>08/05/14 concurrent with the observations, it was acknowledged by the Maintenance Supervisor the two smoke doors leading to a secondary exit and the two exit doors leading directly to the outside from each wing would not unlock when the fire alarm system was tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1. Based on observation and interview, the facility failed to provide directional signs for 2 of 2 possible exit discharge means of egress. LSC 7.7.3 requires the exit discharge shall be arranged and marked to make clear the direction of egress to a public way. This deficient practice could affect at least 3 residents as well as visitors and staff who may not be aware which way to exit out of Therapy.</p> <p>Findings include:</p>	K020047	<p>has been documented.</p> <p>3.The Administrator will test these doors during the August 2014 fire drill to make certain the problem was corrected appropriately.</p> <p>4.The Director of Facility Services will personally test each of the 4 doors quarterly during alarm activation and document these tests on the fire report. This quality assurance audit will occur indefinitely.</p> <p>Maintenance Staff and the contractor who services the fire alarm system, will receive education regarding these requirements. Corrections for this tag will be completed by September 4,2014.</p> <p>K047 This tag was cited due to the exit signs from the Therapy Department not being visible in the hallway. The two illuminated exit signs in that hallway were present and operational at the time of survey, however, they were not visible because lighting had been recently added along the corridor which obscured the signs. In order to correct the problem, an exit sign has been added immediately outside of the therapy gym and the exit signs at the north and south ends of the</p>	09/04/2014	

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K020051 SS=F	<p>Based on observation on 08/05/14 at 12:27 p.m. with the Maintenance Supervisor, there was no exit sign posted in the corridor outside the Therapy room on Therapy hall, ground floor showing a right or left direction to an exit discharge to the public way. Furthermore, standing outside of Therapy one could not see an exit sign in either direction. Based on interview on 08/05/14 at 12:30 p.m. it was acknowledged by the Maintenance Supervisor, the exit door to a public way from the Therapy room was not obvious without an exit sign posted.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72,</p>		hallway have been lowered, thus making them easily observable. There are no other areas of the facility where lighting or other renovations may create a similar problem. However, the Facility Services Director has been educated to consider this with any future renovations. No residents were impacted by this tag. All corrections for this tag will be completed by September4, 2014.		

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	<p>National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 Main fire alarm control panels located in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location. This deficient practice could affect all residents as well as staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation on 08/05/14 at 1:45 p.m. with the Maintenance Supervisor, the Main fire alarm control panel was located in the Employee breakroom on BG wing on first floor was not electrically supervised by a smoke detector. Based on interview on 08/05/14 at 1:47 p.m. with the Maintenance Supervisor, it was acknowledged the Main fire alarm panel located in the</p>	K020051	<p>K051</p> <p>This tag was cited due to the Main Fire Panel not having a hard-wired smoke detector in the immediate area and the Circuit Control box for the Fire Panel not being appropriately marked and labeled with "Fire Alarm Circuit Control", additionally, access was not limited by a locking mechanism to allow access only by authorized staff.</p> <p>This problem was corrected by installing a hard-wired smoke detector, connected to the fire alarm system, adjacent to the Fire Panel. Additionally, a lock was installed on the Fire Alarm Circuit Control box which is now labeled with "Fire Alarm Circuit Control" on the outside. The switch which controls the circuit for the Fire Panel is clearly labeled in red, thus indicating that it controls the Fire Panel.</p> <p>The facility's Maintenance employees will be educated to understand this requirement.</p> <p>All corrections for this tag will be completed by September 4, 2014.</p>	09/04/2014

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	<p>Employee breakroom was not provided with smoke detector protection.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/05/14 at 1:50 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the electrical room adjacent to the Employee breakroom on BG wing on first floor stated "FP" instead of "Fire Alarm Circuit Control" and was accessible to anyone. Based on interview on 08/05/14 at 1:52 p.m. with the Maintenance Supervisor, he acknowledged he was not aware the fire alarm circuit breaker was not fully identified, or the panel box should be locked.</p>			

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K020056 SS=F	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 steel armover sprinkler pipes observed on GG wing Ground floor were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the</p>	K020056	K056 This tag was cited due to three steel armovers of 24 inches in length or greater not having supports to the ceiling. The facility will add supports to each of the three armovers to make certain that there is a support to the ceiling for at least every 24 inches in length. The facility will seek to identify other areas that are potentially impacted by this problem by examining the blue prints of the facility's sprinkler system to identify any other armovers of 24 inches or greater in length. Any need for additional supports will be corrected. (See	09/04/2014

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K020074 SS=D	<p>building as well as staff or visitors if the sprinkler system required repair.</p> <p>Findings include:</p> <p>Based on observations on 08/05/14 at 12:15 p.m. with the Maintenance Supervisor, the following steel sprinkler pipe armovers were observed which exceeded twenty four inches in length and were unsupported:</p> <p>a. Inside room GG16 was a four foot long armover overhead at the south end of the room,</p> <p>b. Outside room GG16 was a four foot long armover suspended from the ceiling,</p> <p>c. Just entering the Therapy corridor on GG wing coming from the Communications wing, a four foot armover was observed suspended from the ceiling.</p> <p>Based on interview on 08/05/14 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armovers exceeded twenty four inches in length and were unsupported.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		Attachment B) The facility's Maintenance staff and contractor for maintaining our sprinkler system will be educated regarding this requirement. All corrections for this tag will be completed by September4, 2014.		

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	<p>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. 18.7.5.1, 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, 18.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Therapy rooms had cubicle curtains installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. The lack of cubicle curtain and sprinkler location coordination may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler. This deficient practice could affect at least 3 residents in the facility as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/05/14 at 12:17 p.m. with the Maintenance Supervisor the three privacy curtains located in Therapy next to the north wall</p>	K020074	<p>K074</p> <p>This tag was cited due to the privacy curtains in the Therapy Gym having a mesh with less than the required ½ inch mesh.</p> <p>The facility has replaced the privacy curtains in the Therapy Gym with the same type of curtain used in all residents' rooms which has the ½ inch mesh/ 70% open weave at the top panel extending greater than 18 inches below the ceiling.</p> <p>The facility will examine all resident rooms within the facility to confirm that only the curtains with ½ inch mesh are being used and we will dispose of any curtains in storage that do not meet the NFPA requirement. A narrative</p>	09/04/2014			

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	lacked a 1/2 inch diagonal mesh or 70 percent open weave top panel extending eighteen inches below the sprinkler deflector. Based on interview on 08/05/14 concurrent with observation made with the Maintenance Supervisor, it was acknowledged all privacy curtains mentioned above had an open diagonal mesh less than one half inch wide. 3.1-19(b)		statement (Quality Assurance Audit) will be written and provided to the department upon request. All facility Maintenance and Housekeeping staff will be educated regarding this requirement. All corrections for this tag will be completed by September 4, 2014.		