

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
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NAME OF PROVIDER OR SUPPLIER WESLEYAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953
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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: 08/05/14</p> <p>Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Wesleyan 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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, in spaces open to the corridors and in the resident rooms. The facility has a capacity of 169 and had</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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K010025 SS=D	<p>a census of 131 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had two detached garages providing facility services including the maintenance supplies, lawn care equipment and paint that were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/11/14.</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 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 maintained to provide</p>	K010025	The collar around the exhaust pipe of the water heater has been corrected, as of 8/06/2014, to provide a one half hour fire	08/06/2014			

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K010029 SS=E	<p>a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect laundry staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Assistant on 08/05/14 at 1:45 p.m., the ceiling of the water heater room located in the laundry had a two inch gap at the exhaust vent pipe of the water heater. The collar around the exhaust pipe was not positioned at the ceiling leaving a gap. The Maintenance Assistant acknowledged the gap at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾</p>		<p>resistance rating. Maintenance will inspect all water heater exhaust piping during the monthly inspection of the water heaters. Documentation of the inspection and any findings will be recorded on the TELS Audit System. The Administrator will monitor TELS on a monthly basis to ensure Preventative Maintenance is being completed in a timely manner.</p>		

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	<p>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 the corridor door to 1 of 8 water heater rooms and 1 of 2 soiled utility rooms on East hall, both are hazardous areas, were self closing and latched into the door frame. This deficient practice could affect 12 residents in Willow Court and 1 of 8 smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Assistant on 08/05/14 at 1:30 p.m., the corridor door to the Willow Court water heater room lacked a self closing device. Based on an interview with the Maintenance Assistant at the time of observation, he acknowledged the water heater room corridor door lacked a self closing device.</p> <p>b. Based on observation with the Maintenance Assistant on 08/05/14 at 1:18 p.m., a magnet covered the striker</p>	K010029	<p>The Willow Court soiled utility door has been corrected, as of 8/11, by installing a door closure on the door. The Fireside Court soiled utility door has been corrected, as of 8/06, by removing the magnet and instructing staff on the hazardous condition being created by placing a magnet or any other object to prevent the door from latching into the door frame. Maintenance will ensure all hazardous areas are properly protected during the monthly TELS Audit inspections. Documentation of the inspections and any findings shall be recorded in the TELS Audit System. The Administrator will monitor TELS on a monthly basis to ensure Preventative Maintenance is being completed in a timely manner.</p>	08/11/2014			

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K010046 SS=F	<p>plate on the door frame to the soiled utility room near the nurses' station on Fireside Court east hall. The corridor door failed to latch into the door frame and could be pushed open without the use of a key or turning the door knob. The Maintenance Assistant acknowledged and removed the magnet at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation and interview, the facility failed to provide emergency task lighting in and around 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA</p>	K010046	The emergency task lighting at the emergency generator has been repaired, as of 8/08, by replacing the faulty unit and testing the new unit. Maintenance will ensure the emergency task lighting is operational through the monthly testing and inspection provided through the TELS Audit Program. Documentation of the inspections and any findings will	08/08/2014			

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K010050 SS=F	<p>110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation and interview with the Maintenance Assistant on 08/05/14 at 2:00 p.m., he acknowledged the battery operated emergency task lighting at the emergency generator failed to illuminate when tested.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to ensure fire drills</p>	K010050	<p>be recorded in the TELS Audit System. The Administrator shall monitor TELS on a monthly basis to ensure that all Preventative Maintenance tasks are being completed in a timely manner.</p> <p>This deficiency shall be corrected upon the next scheduled third shift fire drill dated 9/19.</p>	09/04/2014			

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K010052 SS=E	<p>were conducted quarterly on each shift for 4 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the monthly fire drill documentation titled "Fire Drill Report" with the Maintenance Assistant on 08/05/14 at 10:54 a.m., the third shift fire drills were not actual drills but a question and review session. Based on an interview with the Maintenance Assistant at the time of record review, this is what he was told to do for a third shift fire drill since the fire alarm was not activated.</p> <p>3.1-19(b) 3.1-51(c)</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</p> <p>Based on record review and interview, the facility failed to ensure 39 of 149 smoke detectors were maintained in accordance with the applicable</p>	K010052	<p>Maintenance shall conduct all third shift fire drills as actual fire drills by providing a coded announcement so staff will respond to actual fire drill. Maintenance shall upon completion of all fire drills fax the completed fire drill report to TELS to become an electronic file. Surveyors will have the ability to review all completed audits and reports electronically. The Administrator will monitor TELS on a monthly basis to ensure that all fire drills are being completed in a timely manner and have been faxed to TELS.</p> <p>The 39 smoke detectors have been replaced and tested as of 8/08, to provide proper protection for the coverage area. Maintenance will ensure all</p>	08/08/2014

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	<p>requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test 		<p>smoke detectors are being maintained and tested on an annual basis and during the semi-annual testing. Maintenance will review all service reports to ensure any findings indicating possibly issues will be corrected in a timely manner. Maintenance shall immediatley fax all service reports pertaining to smoke detectors to TELS so they can become an electronic file. The Administrator shall monitor TELS on a monthly basis to ensure all inspections and documentation is being recorded and available for surveyor, if needed.</p>	

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K010062 SS=E	<p>methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect any number of occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Assistant on 08/05/14 at 10:45 a.m., the VFP Fire System smoke detector record titled "Sensitivity Test and Information" stated 39 smoke detectors failed the sensitivity test. Based on an interview with Maintenance Assistant at the time of record review, he was unable to provide documentation to show the smoke detectors had been repaired or replaced.</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>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 activity storage room and 1 of 1</p>	K010062	Automatic sprinkler systems are continuously maintained in reliable operating condition and unobstructed. Maintenance has	08/06/2014			

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	<p>dietary storage room sprinkler heads was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect any number of residents near the activity and dietary storage rooms.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Assistant of 08/05/14 from 12:20 p.m. to 1:00 p.m., numerous items stacked to the ceiling on the top shelf of the shelving unit in the activity storage room and to within six inches of the ceiling in the dietary storage room obstructed the spray pattern of the sprinkler heads. This was acknowledged by the Maintenance Assistant at the time of observations.</p> <p>3.1-19(b)</p>		<p>corrected this deficiency, as of 8/06, by removing the top shelf and instructing staff on the proper distance from the sprinkler head items shall be stored. Maintenance shall ensure facility sprinkler heads are being unobstructed during the monthly TELS Audit Task. Documentation of the TELS Audit Tasks will be recorded upon completion and during the inspection process. The Administrator will monitor the TELS Program on a monthly basis to ensure all audits and tasks are being recorded and available for surveyors, if needed.</p>				