

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/21/2014
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NAME OF PROVIDER OR SUPPLIER  WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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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: 08/21/14</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westminster 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) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. There is no fire separation between the original building and the new Rehabilitation Gym</p>	K010000	<p>Dear Ms. Rhodes, Please find the form CMS-2567 with the plan of correction for the deficiencies sited during the Life Safety Code Survey completed on August 21, 2014. I can be reached at 812-282-9691 ext. 123 if you would have any questions or comments regarding the enclosed documents. Sincerely, Floyd Shewmaker, Administrator Westminster Village preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Village (facility) is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute Westminster Village allegation of Compliance. Date of Compliance by September 20, 2014 in exception to K029 which will be completed on 10/6/2014-10/10/2014.</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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K010018 SS=E	<p>because the original building and Rehabilitation Gym are of the same construction type. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 77 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 08/28/14.</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 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</p>						

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K010029 SS=E	<p>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 2 of 94 resident room corridor doors would latch and resist the passage of smoke. This deficient practice affects 4 residents who reside in resident room 112 and resident room 223.</p> <p>Findings include:</p> <p>Based on observations on 08/21/14 during a tour of the 100 Hall and 200 Hall from 11:45 a.m. to 12:30 p.m. with the director of maintenance, resident room 112 and 223 each had a two inch gap along the top and latching sides of the doors with the doors closed. This was verified by the director of maintenance at the time of observations and acknowledged by the administrator at the 3:20 p.m. exit conference on 08/21/14.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¼</p>	K010018	<p><u>K018</u></p> <p>-</p> <p>Resident room 123 and 112 have been corrected by placing weather stripping to allow the door to seal. The alleged deficiency did not have any affect on any other residents. All doors to be audited to assure no gaps are existing. Proper corrections will be made to assure proper door seal may be found to assure compliance.</p> <p>All doors will be audited by maintenance quarterly to assure that all doors are sealing properly and corrections will be made as needed. The results of the quarterly audit will be reported to the Quality Assurance team at Quality Assurance meeting by Maintenance Director or designee. The threshold of compliance is 100%. This will be completed by September 20, 2014.</p>	09/20/2014

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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 3 kitchen hazardous areas, such as combustible storage rooms over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 68 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 08/21/14 during a tour of the kitchen with the director of maintenance from 10:40 a.m. to 11:05 a.m., the kitchen food storage room, which measured three hundred square feet and stored forty seven shelves of cardboard boxes of food supplies in wooden boxes and paper, lacked a self closing device on the door. The lack of self closing device on the food storage</p>	K010029	<p><u>K029</u></p> <p>-</p> <p>The door to 1 of 3 kitchen hazardous areas will have a self closure device that will cause the door to close and latch into the door. The alleged deficiency did not have any affect on any of the 68 residents identified to be at risk who use the main dining room adjacent to the kitchen. All doors will be audited by maintenance quarterly to assure that all door closure devices are present and working properly and corrections will be made as needed. The results of the quarterly inspection will be reported to the Quality Assurance team at quarterly meeting by Maintenance Director/ Designee. The threshold compliance is 100%. The door materials were ordered on 09/09/2014 and will be installed and corrected 10/06/2014-10/10/2014.</p>	10/10/2014

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K010062 SS=F	<p>room door was verified by the director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</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>1. Based on observation and interview, the facility failed to ensure 5 of 5 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K010062	<p><u>K062</u></p> <p>1. The fire hydrants were inspected on 09/04/2014. The fire hydrants will be inspected annually and after each operation and any necessary corrective action will be taken. This alleged deficiency had no affects on any occupants. Arrangements have been made with current sprinkler contractor to inspect all hydrants on property annually. The annual test has been placed on a preventative maintenance form and the test will be due each year in August. Maintenance Director will add the annual August test of five hydrants to monthly Quality Assurance and will report monthly to Quality Assurance team the month that last test was completed and when the next test is due to be completed.</p>	09/20/2014

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	<p>facility with the director of maintenance on 08/21/14 from 9:35 a.m. to 3:20 p.m., the facility had five fire hydrants located around the facility grounds. Based on an interview with the director of maintenance on 08/21/14 at 11:30 a.m., the local fire department was called over the past year and stated they will no longer conduct an annual inspection on the facilities' private fire hydrants. The lack of an annual inspection for the five fire hydrants was verified by the director of maintenance at the time of interview and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 13 of over 300 sprinklers in the facility covered in corrosion or dust. LSC 9.7.5 requires all automatic sprinkler systems shall 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, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 12 residents who reside on the Skilled Hall and use the</p>		<p>2. This alleged deficient practice did not have any affect on the 12 residents who reside on the Skilled hall and use the Skilled Hall shower room. All sprinkler heads that were noted non-compliant due to dust have been cleaned. All sprinkler heads noted to be non-compliant due to corrosion have been replaced as of 09/04/2014. Audit will be conducted monthly by Maintenance Director/Designee of the basement laundry room, the medical records room, and the skilled hall shower room. Any problems noted will be addressed immediately.</p> <p>3. This alleged deficiency did not have any affect on any residents. All noted escutcheons with gaps have been replaced/ secured. All sprinkler heads will by audited to assure proper seating of the escutcheons by maintenance monthly and those not in compliance will be addressed immediately. The Maintenance Director/Designee will report the monthly audits to the Quality Assurance committee monthly. The threshold compliance is 100%.</p>	

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	<p>Skilled Hall shower room.</p> <p>Findings include:</p> <p>Based on observations on 08/21/14 during a tour of the facility with the director of maintenance from 9:35 a.m. to 3:20 p.m., the basement laundry room eight sprinklers, and the medical records room sprinkler were completely covered in dust. Furthermore, the four sprinklers in the Skilled Hall shower room were completely covered in green corrosion. This was verified by the director of maintenance at the time of observations and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 5 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 68 residents who use the main dining room, located adjacent to the kitchen and 4 residents in rooms 101, 114.</p> <p>Findings include:</p> <p>Based on observations on 08/21/14 during a tour of the facility with the</p>			
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K010130 SS=F	<p>director of maintenance from 9:35 a.m. to 3:20 p.m., the three kitchen sprinkler head escutcheons by the dishwashing machine, the mop sink, the three compartment sink, and resident room 101 bathroom sprinkler escutcheon, and resident room 114 sprinkler escutcheon were not flush to the ceiling leaving between a one inch gap and a two inch gap into the attic space above. This was verified by the director of maintenance at the time of observations and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 3 of 3 boilers had inspection certificates that were current to ensure the boilers were in safe operating condition. NFPA 101, in 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 could affect all residents in the facility.</p> <p>Findings include:</p>	K010130	<p>K130</p> <p>-</p> <p>This alleged deficiency had no affect on any residents in the facility. The noted boiler inspection certificates were not present at the time of survey. Copies of the current inspection certificates were obtained from the Indiana Boiler &amp; Pressure Vessel Section. The Certificate of Inspection expires on 10/26/2014 on all 3 boilers. The maintenance Director/Designee will audit all Certificate of Inspection reports quarterly to assure compliance. The Maintenance</p>	09/20/2014

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K020000	<p>Based on review of the three Hydrotherm model boilers inspection certificates with the director of maintenance on 08/21/14 at 10:45 a.m., the inspection certificates for boiler #297716, #297717, and #297718 each had an expiration date of 08/27/12. Based on an interview with the director of maintenance on 08/21/14 at 11:00 a.m., it was stated there are no current two year inspection certificates for the three Hydrotherm model boilers. The lack of current inspection certificates for the three Hydrotherm model boilers was verified by the director of maintenance at the time of interview and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</p> <p>3.1-19(b)</p> <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: 08/21/14</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>Surveyor: Mark Bugni, Life Safety Code</p>	K020000	<p>Director/Designee will report at quarterly Quality Assurance meetings the results of the quarterly audits. The threshold of compliance will be 100%.</p> <p>Dear Ms. Rhodes, Please find the form CMS-2567 with the plan of correction for the deficiencies sited during the Life Safety Code Survey completed on August 21, 2014. I can be reached at 812-282-9691 ext. 123 if you would have any questions or comments regarding the enclosed documents. Sincerely, Floyd Shewmaker, Administrator Westminster Village preparation and execution of this plan of correction does not constitute an admission or agreement by the</p>	

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	<p><b>Specialist</b></p> <p>At this Life Safety Code survey, Westminster 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) and 410 IAC 16.2. The 2009 Rehabilitation Gym was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This 2009 addition to the one story facility was determined to be of Type V (111) construction and fully sprinkled. 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 94 and had a census of 77 in the healthcare portion of the facility at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>		<p>provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Village (facility) is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute Westminster Village allegation of Compliance. Date of Compliance by September 20, 2014 in exception to K029 which will be completed on 10/6/2014-10/10/2014.</p>		

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K020029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 kitchen hazardous areas, such as combustible storage rooms over 50 square feet in size, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect any Rehabilitation Gym residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 08/21/14 during a tour of the kitchen with the director of maintenance from 10:40 a.m. to 11:05 a.m., the kitchen food storage room, which measured three hundred square feet and stored forty seven shelves of cardboard boxes of food supplies in wooden boxes and paper, lacked a self closing device on the door. The lack of self closing device on the food storage room door was verified by the director of</p>	K020029	<p><u>K029</u></p> <p>-</p> <p>The door to 1 of 3 kitchen hazardous areas will have a self closure device that will cause the door to close and latch into the door. The alleged deficiency did not have any affect on any of the 68 residents identified to be at risk who use the main dining room adjacent to the kitchen. All doors will be audited by maintenance quarterly to assure that all door closure devices are present and working properly and corrections will be made as needed. The results of the quarterly inspection will be reported to the Quality Assurance team at quarterly meeting by Maintenance Director/ Designee. The threshold compliance is 100%. The door materials were ordered on 09/09/2014 and will be installed and corrected 10/06/2014-10/10/2014.</p>	10/10/2014

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K020062 SS=F	<p>maintenance at the time of observation and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 5 of 5 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents to the Rehabilitation Gym.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the director of maintenance</p>	K020062	<p><u>K062</u></p> <p>1. The fire hydrants were inspected on 09/04/2014. The fire hydrants will be inspected annually and after each operation and any necessary corrective action will be taken. This alleged deficiency had no effects on any occupants. Arrangements have been made with current sprinkler contractor to inspect all hydrants on property annually. The annual test has been placed on a preventative maintenance form and the test will be due each year in August. Maintenance Director will add the annual August test of five hydrants to monthly Quality Assurance and will report monthly to Quality Assurance team the month that last test was completed and when the next test is due to be completed.</p> <p>2. This alleged deficient practice</p>	09/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  08/21/2014
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NAME OF PROVIDER OR SUPPLIER  WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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K020130 SS=F	<p>on 08/21/14 from 9:35 a.m. to 3:20 p.m., the facility had five fire hydrants located around the facility grounds. Based on an interview with the director of maintenance on 08/21/14 at 11:30 a.m., the local fire department was called over the past year and stated they will no longer conduct an annual inspection on the facilities' private fire hydrants. The lack of an annual inspection for the five fire hydrants was verified by the director of maintenance at the time of interview and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 3 of 3 boilers had inspection certificates that were current to ensure the boilers were in safe operating condition. NFPA 101, in</p>	K020130	<p>did not have any affect on the 12 residents who reside on the Skilled hall and use the Skilled Hall shower room. All sprinkler heads that were noted non-compliant due to dust have been cleaned. All sprinkler heads noted to be non-compliant due to corrosion have been replaced as of 09/04/2014. Audit will be conducted monthly by Maintenance Director/Designee of the basement laundry room, the medical records room, and the skilled hall shower room. Any problems noted will be addressed immediately.</p> <p>3. This alleged deficiency did not have any affect on any residents. All noted escutcheons with gaps have been replaced/ secured. All sprinkler heads will by audited to assure proper seating of the escutcheons by maintenance monthly and those not in compliance will be addressed immediately. The Maintenance Director/Designee will report the monthly audits to the Quality Assurance committee monthly. The threshold compliance is 100%.</p> <p><u>K130</u></p> <p>-</p> <p>This alleged deficiency had no affect on any residents in the facility. The noted boiler inspection certificates were not present at the time of</p>	09/20/2014

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	<p>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 could affect all residents in the Rehabilitation Gym.</p> <p>Findings include:</p> <p>Based on review of the three Hydrotherm model boilers inspection certificates with the director of maintenance on 08/21/14 at 10:45 a.m., the inspection certificates for boiler #297716, #297717, and #297718 each had an expiration date of 08/27/12. Based on an interview with the director of maintenance on 08/21/14 at 11:00 a.m., it was stated there are no current two year inspection certificates for the three Hydrotherm model boilers. The lack of current inspection certificates for the three Hydrotherm model boilers was verified by the director of maintenance at the time of interview and acknowledged by the administrator at the exit conference on 08/21/14 at 3:20 p.m.</p> <p>3.1-19(b)</p>		<p>survey. Copies of the current inspection certificates were obtained from the Indiana Boiler &amp; Pressure Vessel Section. The Certificate of Inspection expires on 10/26/2014 on all 3 boilers. The maintenance Director/Designee will audit all Certificate of Inspection reports quarterly to assure compliance. The Maintenance Director/Designee will report at quarterly Quality Assurance meetings the results of the quarterly audits. The threshold of compliance will be 100%.</p>		