

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 09/15/2015
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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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K 0000 Bldg. 01	<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: 09/15/15</p> <p>Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240</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, spaces open to the corridors and in the resident rooms. The facility has a capacity of 169 and had a census of 128 at the time of this survey.</p>	K 0000		
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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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K 0018 SS=B Bldg. 01	<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 completed 09/17/15 - DA</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 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 there were no impediments to the closing of 5 of 90 resident room doors of the facility protecting corridor openings. This deficient practice could affect 50 residents of the facility.</p> <p>Findings include:</p>	K 0018	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are not to have any "impediment to the closing of the doors. 19.3.6.3Facility failed to ensure there were no impediments to the closing of 5 of 90 residents room doors of the facility protecting corridor openings. The facility	10/06/2015

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	<p>Based on observation during a tour of the facility with the Maintenance supervisor on 9/15/15 at between 11:03 a.m. and 12:11 p.m., the corridor door to resident rooms 1, 9, 10, 13, and 76 were obstructed by a trash can propping the doors open. Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p>		<p>shall have the corridor doors to residents rooms 1, 9, 10, 13, and 76 readjusted to ensure the doors will not have any impediment required to close the doors into their frame. This shall be completed by October 6, 2015. Maintenance shall complete the setup TELS Monthly Task Review Resident Rooms which requires resident room doors to be checked. Such check requires doors to close without any impediment. Administrator shall monitor TELS monthly to ensure all tasks are being completed on time. We are requesting paper compliance.</p>	

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K 0025 SS=E Bldg. 01	<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 were maintained to provide 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 could affect 65 residents in 5 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with Maintenance Supervisor on 09/15/15 between 10:15 a.m. and 12:30 p.m., the following ceiling smoke barrier had penetrations sealed with an un-rated material:</p> <p>a) In the ceiling of the electrical room by the generator there were ten penetrations around wires and conduits filled with a gray caulk.</p> <p>b) In the ceiling of the phone room there</p>	K 0025	<p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Facility failed to ensure ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. Ceiling smoke barrier had penetrations sealed with an un-rated material. NOTE: Areas-a.b.c.d. were alleged by the surveyor to have been sealed with gray caulk which was not Fire Rated. However, the facility has a documentation to verify the caulking used to provide at least a one half hour fire resistance rating is a Fire Rated Caulk. This documentation has been attached to this POC for your review. Therefore, the facility has met the requirements of LSC 8.3.2 by providing the proper Fire Rating Resistance to seal Smoke Barriers. Maintenance shall ensure all future penetrations have been properly sealed with Fire Rated caulking.</p>	10/06/2015

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K 0029 SS=E Bldg. 01	<p>were four penetrations around wires and conduits filled with a gray caulk.</p> <p>c) In the ceiling of the electrical room on Memory Lane there were ten penetrations around wires and conduits filled with a gray caulk.</p> <p>d) In the ceiling of the electrical room on Willow Court there were five penetrations around wires and conduits filled with a gray caulk.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor did not know if the gray caulk was an approved material and did not have the documentation to show if the caulk met the requirements for use in through penetration fire stop systems.</p> <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>		Maintenance shall ensure any and all outside contractors complete their work with sealing all penetrations they may have made in smoke barriers with Fire Rated caulking. Administrator shall monitor all contractual work completed in the facility on a amonthky basis. We are requesting paper compliance.	

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	<p>Based on observation and interview, the facility failed to ensure 3 of 5 a hazardous areas, such as a boiler room, was smoke resistive. This deficient practice could affect 55 residents in 3 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 09/15/15 between 10:45 a.m. and 12:30 p.m., the fowling hazardous areas had penetrations sealed with an un-rated material:</p> <ol style="list-style-type: none"> 1) In the locker room, which contained a hot water heater, there were two penetrations around pipes sealed with a gray caulk. 2) In the electric room on Fireside hall, which contained a hot water heater, there were five penetrations sealed with a gray caulk. 3) In the mechanical room on Willow Court, which contained a hot water heater, there were three penetration sealed with a gray caulk. <p>Based on interview at the time of observation, the Maintenance Supervisor did not know if the gray caulk was an approved material and did not have the documentation to show if the foam met the requirements for use in through penetration fire stop systems.</p>	K 0029	<p>Hazardous areas shall be protected and separated from other spaces by smoke resiting partiions and doors. 19.3.2.1 Facility failed to ensure 3 of 5 hazardous areas were smoke resistive due to penetrations being sealed with an unrated material. NOTE: Areas-a.b.c.d. were alleged by the surveyor to have been sealed with gray caulk which was not Fire Rated. However, the facility has a documentation to verify the caulging used to provide at least a one half hour fire resistance rating is a Fire Rated Caulk. This documentation has been attached to this POC for your review. Therefore, the facility has met the requirement of LSC 8.3.2 by providing the proper Fire Rating Resistance to seal Smoke Barriers. Maintenance shall ensure all future penetrations have been properly sealed with Fire Rated caulking. Maintenance shall ensure any and all outside contrators complete their work with sealing all penetrations they may have made in smoke barriers with Fire Rared cualking. Administrator shall monitor all contractual work completed in the facility on a monthly basis. We are requesting paper compliance.</p>	10/06/2015			

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K 0062 SS=E Bldg. 01	<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 record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 09/15/15 at 09:35 a.m., the report titled "Report of 5 year Inspection and Testing" indicated an internal inspection of the pipes had been completed on 4-08-2010. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to show an internal pipe inspection was completed in the last five years.</p>	K 0062	<p>Automatic sprinkler systems are required to be 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 Facility failed to ensure the dry sprinkler piping system was inspected every five years. No documentation was available to show an internal pipe inspected was completed in the last five years. Facility failed to replace one sprinkler head in room 13 which had paint on the fusible link and deflector. NFPA 25 requires any sprinkler shall be replace when painted, corroded, damaged, loaded, or in the improper orientation. Maintenance shall schedule with Sprinkler Service Company to have the five year internal pipe inspection completed by October 6, 2015. Maintenance shall have the sprinkler head replaced by October 6, 2015. Maintenance shall make a Quarterly Review of all sprinkler heads to ensure</p>	10/06/2015

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K 0064 SS=B	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 3 sprinklers in room 13 which had been painted. 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 2 residents in room 13.</p> <p>Findings include:</p> <p>Based on observation during the tour with the Maintenance Supervisor on 09/15/15 at 11:00 a.m., 1 of 3 sprinkler heads in room 13 had paint on the fusible link and deflector. Based on interview at the time of observation, the painted sprinkler head was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		heads are clean and free from paint, corrosion, damage and improper orientation. The administrator to ensure maintenance has completed the required task by reviewing the TELS Program routinely. We are requesting paper compliance.				

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Bldg. 01	<p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect 60 residents using the main dining room and all kitchen staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor</p>	K 0064	<p>Portable Fire Extinguishers are to be maintained and have the proper placard in place next to the K Class portable fire extinguisher: NFPA 10 2-3.2.1 Facility failed to ensure the required placard was in place next to the K Class extinguisher in the kitchen. Maintenance shall ensure the proper placard with the correct wording which states "the fire protection system shall be activated prior to using the fire extinguisher". This task shall be completed by October 6, 2015. Maintenance shall make a Monthly Review of all K Class Fire Extinguishers in the facility to ensure placards are installed and maintained. Administrator shall monitor maintenance to ensure this task has been completed and review while making routine rounds in the building. Request paper documents.</p>	10/06/2015	

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	<p>on 09/15/15 at 10:40 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview at the time of observation, the Maintenance Supervisor confirmed the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p>				