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 06/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEYAN HEALTH CARE CENTER	729 W 35TH ST MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	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). Survey Date: 06/13/12 Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240 Surveyor: Amy Kelley, Life Safety Code Specialist 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. This one story facility was determined to be of Type V (111) construction and was fully	K0000	K 000 This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal laws and regulations and not because Wesleyan Health Care Center agrees with the allegations and citations listed. Wesleyan Health Care Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such a character so as to limit our capabilities to render adequate care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident rooms with the exception of the resident rooms located on Harbor Lane, Memory Lane and Willow court. The facility has a capacity of 169 and had a census of 126 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/18/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5			
	Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in the Cova Way mechanical room were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident near the Cova Way mechanical room in the event of a fire emergency. Findings include: Based on observation with the Maintenance Supervisor on 06/13/12 at 12:40 p.m., the Cova Way mechanical room located in	K0056	K056 Corrective Actions taken for those residents affected by the alleged deficient practice: The sprinkler heads in the Cova Way mechanical room have been corrected to be six feet apart. Identification of and Corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents residing on or near Cova Way have the potential to be affected by the alleged deficient practice in the event of an emergency. The sprinkler heads have been corrected to six feet apart as of 6/14/2012. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: Maintenance Director/Designee will inspect sprinkler heads through out the facility for correct spacing and corrected immediately with any findings reported to the Administrator. How the Corrective Actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: The reports of findings will be reviewed	06/14/2012

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	the Cova Way corridor had two sprinkler heads located thirty six inches apart. Measurements were provided by the Maintenance Supervisor. At the time of observation the Maintenance Supervisor acknowledged the sprinkler heads in the Cova Way mechanical room were less than six feet apart. 3.1-19(b)		at the quarterly QA meeting for compliance. Completion Date: 6/14/2012	

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K0062 SS=D	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 Based on observation and interview, the facility failed to ensure 2 of 2 shower curtains installed in shower room # 24 in Harbor Lane were in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Because of the lack of shower curtain and sprinkler location coordination which may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler, this deficient practice could affect any resident in the two shower bays as well as any staff in shower room # 24 in Harbor Lane. Findings include: Based on observations with the Maintenance Supervisor on 06/13/12 at 11:30 a.m., both shower curtains in shower room # 24 in Harbor Lane lacked 1/2 inch diagonal mesh or a 70 percent open weave top panel extending	K0062	K062 Corrective Actions Taken for Those residents affected by the alleged deficient practice: The shower curtain was replaced at the time of survey. Identification of and the corrective actions taken for other resident having the potential to be affected by the alleged deficient practice: All residents on harbor lane near the shower room have the potential to be affected by the alleged deficient practice in the event of an emergency. The shower curtain has been replaced with a shower curtain that has mesh. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: Maintenance Director/Designee will inspect all shower rooms for safety compliant shower curtains and make corrections if necessary. Maintenance Director/Designee will report all findings to administrator. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: The reports of findings from inspections will be reported to the administrator and reviewed in the quarterly QA meeting. Completion Date: 6/14/2012	06/14/2012

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	18 inch below the sprinkler deflector. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen cylinders in the Harbor Lane oxygen storage room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any residents or staff at the Harbor Lane nurses' station or other areas near the oxygen storage room. Findings include: Based on an observation with the Maintenance Supervisor on 06/13/12 at 11:15 a.m., there was an unsupported "H" cylinder	K0076	K076 Corrective Actions taken for those residents affected by the alleged deficient practice: The oxygen cylinder was immediately secured in the oxygen room per standards. Identification of and Corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. The oxygen cylinder was immediately secured in the oxygen room per standards during the survey. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: Maintenance Director/Designee has audited the oxygen rooms in the facility to ensure that oxygen cylinders are properly secured per standards. Any findings will be corrected as necessary and reported to the Administrator. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: Maintenance Director/Designee has audited the oxygen rooms in the facility to ensure that oxygen cylinders are properly secured per standards. Any	06/14/2012

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	of compressed oxygen in the Harbor Lane oxygen storage room. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		findings will be corrected as necessary and reported to the Administrator. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: A quality assurance audit will be completed by the Maintenance Director/ Designee to ensure that the oxygen tanks are secured properly in the oxygen rooms three times per week for three months then weekly there after. The results will be forwarded to the quarterly QA meetings for review and any concerns addressed. Completion Date:6/14/2012	