

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2014
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NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
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K030000	<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: 06/30/14</p> <p>Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westside Retirement Village 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.</p> <p>A one story building addition of Type II (000) construction was approved on 08/24/2007 and the major renovation of the original one story building of Type II (222) construction was approved 05/28/2008.</p>	K030000		
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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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K030029 SS=E	<p>This one story facility was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 132 and had a census of 101 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14.</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 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</p>						

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	<p>are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on record review, observation and interview; the facility failed to ensure 2 of 10 doors serving hazardous areas such as combustibile storage rooms over fifty square feet in size were enclosed with a 3/4-hour fire rated door. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Assistant Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/30/14, the storage room by Room 111 and the Chart Room by the Day Room were each converted from office space to storage rooms full of combustibile boxes. The corridor door to each room had a 20 minute fire resistance rating label affixed to the door. The storage room by Room 111 measured 64 square feet in size and the Chart Room measured 80 square feet in size. Based on record review at the time of the observations, the Maintenance Director acknowledged the fire resistance rating of the aforementioned doors was each less than 3/4-hour.</p> <p>3.1-19(b)</p>	K030029	A new 45 minute Fire Rated door has been ordered in each location in question on 7/18/2014. The doors will be installed upon delivery. Other doors in the facility have been inspected by Maintenance Director for safety compliance and proper fire rating. Other doors installed in the future will be inspected by Maintenance Director prior to installation for proper fire rating.	07/30/2014			

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K030038 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>1. Based on observation and interview, the facility failed to ensure the means of egress through 4 of 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 18.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p>	K030038	The codes to release the magnetically locked doors in question were posted on 7/1/14. The appropriate signage was applied to the doors in question. Other doors throughout the facility were inspected on 7/1/14 to assure the codes to release were posted and signage indicating "Pushing the door for 15 seconds will release door" was present. Maintenance Director will inspect doors for proper function and proper signage. Results of the inspections will be presented to the Quality Assurance Committee on a monthly basis.	07/30/2014

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	<p>Based on observations with the Maintenance Director and Assistant Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/30/14, the corridor door to the former Alzheimer's area exit by Room 204, the former Alzheimer area Dining Room, the exit by Room 208 and the Main Dining Room exit were each marked as a facility exit, each exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. In addition, at the entrance to the former Alzheimer's area opposite Room 204 on the Associates Breakroom side of the door the four digit code was posted but the posted code was not the correct code to release the magnetic lock. Based on interview at the time of observation, the Maintenance Director stated the facility no longer has a dedicated wing for residents who have a clinical diagnosis to be in a secure building and acknowledged the four digit code was not posted at each of the aforementioned facility exits. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview,</p>			

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	<p>the facility failed to ensure the means of egress through 1 of 10 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in</p>			

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	<p>stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS.</p> <p>This deficient practice could affect 20 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Assistant Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/30/14, the Main Dining Room exit is marked as a facility exit and is equipped with a delayed egress lock but is not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. The exit door released within 15 seconds when the door was pushed with the application of force two separate times. Based on interview at the time of observation, the Maintenance Director stated the aforementioned exit door is a facility exit, is equipped with a delayed egress lock and acknowledged the Main Dining Room exit is not provided with necessary signage stating the door could be opened in 15 seconds by pushing on the door release device.</p>						

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K030048 SS=C	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 75 of 75 resident sleeping rooms. LSC 18.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all</p>	K030048	A Fire Safety Plan that meets the established criteria will be implemented by 7/30/14. All of the residents and future residents will benefit in the event of a fire emergency by the implementation of this plan. The staff will be inserviced on the changes to the plan that addresses the emergency response of staff as it pertains to activation of battery operated smoke detectors. The new fire emergency plan will be reviewed by the Quality Assurance Committee. All fire drills will be reviewed by the Quality Assurance Committee on a monthly basis for the next 6 months to assure compliance.	07/30/2014	

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	<p>residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Safety Plans" documentation with the Maintenance Director during record review from 9:30 a.m. to 12:15 p.m. on 06/30/14, the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. Based on observations with the Maintenance Director and Assistant Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/30/14, battery operated smoke detectors are installed in each resident sleeping room. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p>						

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K030050 SS=C	<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. 18.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Direct Supply Tels Logbook Documentation: Fire Drills" and "Fire Drill Report" documentation with the Maintenance Director during record review from 9:30 a.m. to 12:15 p.m. on 06/30/14, the following was noted:</p> <p>a. first shift fire drills conducted on 07/30/13, 10/07/13 and 01/09/14 were each conducted at, respectively, 1:45 p.m., 1:00 p.m. and 1:00 p.m.</p> <p>b. second shift fire drills conducted on 08/27/13, 11/27/13, 02/17/14 and 05/30/14 were conducted at, respectively, 3:30 p.m., 3:45 p.m., 3:00 p.m. and 3:00</p>	K030050	<p>Fire Drills will be held by 7/30/14 on all shifts at times that have not been routinely used. All residents in the facility could be effected by this alleged deficient practice. The Maintenance Director will develop a new Fire Drill Schedule that will be approved by the Administrator. The new schedule will indicate times that will show no pattern in order to be unexpected from month to month. This will better prepare the staff to assist the residents in the event of a fire emergency. Results of the fire drills and times will be reviewed by the Quality Assurance Committee on a monthly basis to assure compliance. The Quality Assurance Committee will review the fire drills on a monthly basis for 6 Months to assess staff response and review times of drills.</p>	07/30/2014

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K030052 SS=E	<p>p.m. c. third shift fire drills conducted on 09/30/13, 12/31/13 and 03/31/14 were each conducted at 6:00 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned fire drills for each shift were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</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 Based on observation and interview, the facility failed to install 1 of 184 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in</p>	K030052	The smoke detector in question has been relocated to a location in excess of 3 feet from the air return on 7/1/14. Smoke detectors throughout the facility were inspected for proper location to meet code on 7/1/14 by the Maintenance Director. The smoke detectors will be routinely inspected and cleaned on a monthly basis by the Maintenance Director to maximize	07/30/2014

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K030130 SS=F	<p>a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 16 residents, staff and visitors in the vicinity of Room 105.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Assistant Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/30/14, the smoke detector on the ceiling in the corridor outside Room 105 was located eight inches from an air return. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke detector was installed on the ceiling less than three feet from an air return.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p>		effectiveness for the safety of residents, staff and visitors. Results of inspections will be reviewed by the Quality Assurance Committee on a monthly basis for 6 months. Any future installations of smoke detectors will be installed in a location that meets the regulatory code.				

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	<p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 75 of 75 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Direct Supply Tels Logbook Documentation: Detectors" with the Maintenance Director during record review from 9:30 a.m. to 12:15 p.m. on 06/30/14, the following was noted:</p> <p>a. an itemized listing of battery operated smoke detector testing for the most recent twelve month period was not available for review, instead the testing results for battery operated smoke detectors in resident sleeping rooms are documented as the total number tested on a monthly basis.</p> <p>b. documentation of battery operated smoke detector cleaning within the most recent twelve month period was not available for review.</p> <p>c. logbook documentation for monthly testing completed on 02/14/14 stated 70</p>	K030130	Battery operated smoke detectors throughout the facility will be cleaned, tested and logged by the Maintenance Director on an itemized log indicating which room the detector was located by 7/30/14. The battery operated smoke detectors will be cleaned and tested on a monthly basis per manufacturers specifications and logged by the Maintenance Director on the itemized log. The logs will be reviewed by the Quality Assurance Committee on a monthly basis for 6 months to assure compliance.	07/30/2014

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K030147 SS=D	<p>of 75 resident sleeping room smoke detectors were tested.</p> <p>Based on observations with the Maintenance Director and Assistant Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/30/14, BRK Model FG250 battery operated smoke detectors are installed in each of 75 resident sleeping rooms.</p> <p>Based on a review of manufacturer's specifications for BRK Model FG250 battery operated smoke detectors, monthly testing and cleaning is required.</p> <p>Based on interview at the time of record review and of the observations, the Maintenance Director acknowledged an itemized listing of battery operated smoke detector testing and cleaning for each smoke detector for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>			
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NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234		
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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two staff and visitors in the Housekeeping Supply Office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Assistant Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 06/30/14, a refrigerator and a coffee pot were plugged into a power strip in the Housekeeping Supply Office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring in the Housekeeping Supply Office.</p> <p>3.1-19(b)</p>	K030147	<p>The power strip in the Housekeeping Supply Office was removed and the appliances were plugged directly into wall socket by the Maintenance Director. Effective 7/1/14 any appliance that exceeds the allowable voltage will be powered through a fixed wiring. The Maintenance Director inspect the facility to assure no other power strips were utilized in inappropriate areas. Prior to a power strip being utilized the Maintenance Director will review the appliance to assure compliance. The Maintenance Director will make documented inspections throughout facility on a monthly basis to assure no inappropriate power strips are utilized. Results of the inspections will be reviewed by the Quality Assurance Committee for 6 months to assure compliance.</p>	07/30/2014	