STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	155135	A. BUILDING 01 / B. WING	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0000 Bldg. 01	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: 04/27/2016 Facility Number: 000060 Provider Number: 155135 Aim Number: 100266600 At this Life Safety Code Survey, Westview Nursing and Rehabilitation 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 with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident sleeping rooms in Cottage Hall are provided with smoke	K 0000	This plan of Correction constitutes my written allegation ofcompliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission thatthe deficiency exists or that on was cited correctly. This Plan of Correction is submitted to meetrequirements by state and federal law. Westview Nursing and Rehabilitation Center is requesting paper compliance	

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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	detectors hard wired to the fire alarm system. Battery operated smoke detectors are installed in all other resident sleeping rooms. The facility has a capacity of 95 and had a census of 67 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has one detached storage building which was not sprinklered. Quality Review completed on 05/04/16 - DA			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure ensure 1 of 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the main entrance lobby. Findings include:	K 0025	**K 025 NFPA 101 LifeSafety Code What correctiveaction will be accomplished for those resident s found to have been affected bythe deficient practice?** The three foot by one foot ceiling tiles were placed in the business office closet which provides a least a one half hour fire resistance rating and constructed in accordance with 8.3. **How other residentshaving the potential**	05/10/2016

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	Based on observation with the Environmental Director during a tour of the facility from 12:10 p.m. to 2:50 p.m. on 04/27/16, a three foot by one foot section of ceiling tile was missing in the Business Office closet which exposed the attic above. Based on interview at the time of observation, the Environmental Director acknowledged the aforementioned location had a section of ceiling tile missing which failed to maintain the ceiling smoke barrier and exposed the attic above. 3.1-19(b)		**to be affected by the same deficient practice will beidentified and what corrective actions will be taken?** All 20 staff and visitors have the potential to be affectedby the deficient practice. All closets in the facility were checked to ensure the ceiling tiles provides a one half hour fire resistance rating and constructed in accordance with 8.3. The Environmental Director in-serviced all environmental staff to ensure this deficient practice is identified. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** The Environmental Director and/or Designee will audit all the closets in the facility to ensure that all ceiling tiles provide a one half hour fire resistance rating and constructed in accordance with 8.3. The Executive Director and/or Designee will review the log monthly. **How will thecorrective actions be maintained to ensure the deficient practice will notrecur?** To ensure compliance, the Environmental Director and/orDesignee will bring the log to the monthly Quality Assurance Meeting forreview. The Environmental Directorand/or Designee will audit monthly all closets for 6 months. The findings of the Quality Assurance checkwill be documented and	

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			submitted in monthly Quality Assurance Meetings. Westview Nursing and Rehabilitation Center is requesting paper compliance. **Completion date: 05-10-2016**	
K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on review of Vanguard Alarm Services "Periodic Range Hood & Suppression System Testing and Inspection Report" documentation dated 02/02/15 and 08/19/15 with the Environmental Director during record review from 9:30 a.m. to 12:10 p.m. on 04/27/16, documentation of semiannual hood extinguishing systems inspection six months after 08/19/15 was not	K 0069	**K 069 NFPA 101 LifeSafety Code What correctiveaction will be accomplished for those resident s found to have been affected bythe deficient practice?** The Environmental Director called our kitchen range hoodsuppression system inspection contractor and the hood extinguishing system inthe kitchen was inspected and serviced on May 5, 2016. **How other residentshaving the potential to be affected by the same deficient practice will beidentified and what corrective actions will be taken?** Five staff and visitors could have the potential to beaffected by the deficient practice. TheEnvironmental Director in-serviced all environmental staff to ensure thisdeficient practice is identified. TheOne of one hood extinguishing systems in the kitchen will be put on a monthlylog to ensure that this is being met by NFPA 96, the Standard for VentilationControl and Fire Protection of Commercial Cooking Operations	05/06/2016

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	available for review. Based on interview at the time of record review, the Environmental Director stated the facility changed kitchen range hood suppression system inspection contractors sometime after August 2015 and acknowledged documentation of semiannual hood extinguishing systems inspection six months after to 08/19/15 was not available for review. 3.1-19(b)		with inspectionsevery 6 months. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** The Environmental Director and/or Designee will do monthlyaudit ensure that this is being met by NFPA 96, the Standard for VentilationControl and Fire Protection of Commercial Cooking Operations with inspectionsevery 6 months. The Executive Directorand/or Designee will review the log monthly. **How will thecorrective actions be maintained to ensure the deficient practice will notrecur?** To ensure compliance, the Environmental Director and/orDesignee will bring the log to the monthly Quality Assurance Meeting forreview. The Environmental Directorand/or Designee will audit monthly inspections for 6 months to ensure the inspections are in place to be inspected every 6 months. The findings of the Quality Assurance check will be documented and submitted in monthly Quality Assurance Meetings. Westview Nursing and Rehabilitation Center is requesting paper compliance. **Completion date: 05-06-2016**	
K 0076 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with			

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	NFPA 99, Standard 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. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 Based on record review, observation and interview; the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet were enclosed with a separation of 1 hour fire resistive construction. This deficient practice could affect 5 staff and visitors in the vicinity of the oxygen storage and transfilling room by the employee breakroom. Findings include: Based on observation with the Executive Director and the Environmental Director during a tour of the facility from 12:10 p.m. to 2:50 p.m. on 04/27/16, the ceiling of the oxygen storage and transfilling room by the employee breakroom consisted of acoustical tiles in a suspended ceiling. No fixed fire rated ceiling was located above the suspended ceiling which exposed the attic above when a tile was lifted. The aforementioned room contained six liquid oxygen containers. Based on	K 0076	**What corrective action will be accomplished for those resident s found to have been affected bythe deficient practice?** The ceiling tiles were replaced in the oxygen storage room by ceiling tiles with a separation of one hour fire resistive tiles. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All 5 staff and visitors have the potential to be affected by the deficient practice. The Environmental Director in-serviced all environmental staff to ensure this deficient practice is identified. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** The Environmental Director and/or Designee will do audit theoxygen storage room to ensure that all ceiling tiles with a separation of onehour fire resistive are in place. TheExecutive Director and/or	05/10/2016

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	interview at the time of observation, the Executive Director stated she was unaware of the fire resistance rating of the acoustical tiles and acknowledged the attic above was exposed when a tile was lifted. Based on review of USG "Frost Panels" acoustical ceiling tile documentation during the exit interview at 3:00 p.m., a Class A flame spread rating was stated as the thermal resistance of the acoustical panels. No fire resistance rating was stated in the aforementioned documentation. Based on interview at the time of the exit interview, the Executive Director and the Environmental Director acknowledged the fire resistance rating of the suspended ceiling was not known and it could not be assured the oxygen storage room and transfilling room was enclosed with one hour fire resistive construction. 3.1-19(b)		Designee will review the log monthly. **How will thecorrective actions be maintained to ensure the deficient practice will notrecur?** To ensure compliance, the Environmental Director and/orDesignee will bring the log to the monthly Quality Assurance Meeting forreview. The Environmental Directorand/or Designee will audit monthly all closets for 6 months. The findings of the Quality Assurance checkwill be documented and submitted in monthly Quality Assurance Meetings. Westview Nursing and Rehabilitation Center is requesting paper compliance. **Completion date: 05-10-2016**	