

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2012
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
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K0000	<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: 06/08/12</p> <p>Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westminster Village North 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, and 410 IAC 16.2. Building 0101 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0101 built in 1974 was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with</p>	K0000		

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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	<p>smoke detection in the corridors and in all areas open to the corridor. The resident sleeping rooms were provided with battery operated smoke detectors. The facility has a capacity of 123 and had a census of 94 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0011 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers to a nonconforming building was protected by a two hour fire wall. This deficient practice could affect any resident, staff or visitor in the vicinity of the Riley South hall breezeway by Room 124 which leads to the Assisted Living building.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Campus Environment, the Director of Environmental Services and the Plant Operations Assistant from 11:40 a.m. to 2:20 p.m. on 06/08/12, the firewall which separates the Riley South hall breezeway from the Assisted Living building has a four inch by two inch opening through the firewall above the ceiling by the Riley South hall exit door which was not firestopped. Based on interview at the time of observation, the Plant Operations Assistant acknowledged the firewall</p>	K0011	<p>This Plan of Correction shall serve as our credible allegation of compliance, effective July 8th, 2012. K 011 Fire Barriers Westminster Village North's technician has made the necessary repair to close the four inch by two inch opening through the firewall above the ceiling with proper materials including nonflammable, fire resistant rated caulk. An inspection was conducted of other fire walls to make sure there were no penetrations. No residents were affected. Going forward, the Plant Operations Manager will work directly with staff and vendors and have ongoing discussion about this code. A final inspection of work done in the area will be made by the Plant Operations Manager to ensure that it is performed in accordance with Life Safety Code standards. The Director of Campus Environment with the Plant Operations Manager will ensure compliance by completing visual assessments on an ongoing basis but each quarter at a minimum.</p>	07/08/2012

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	above the ceiling by the Riley South hall exit door had a four inch by two inch opening in the wall which was not firestopped. 3.1-19(b)			

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K0029 SS=E	<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> <p>1. Based on observation and interview, the facility failed to ensure 1 of 11 doors serving hazardous areas such as a soiled linen room is 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 resident, staff or visitor in the vicinity of the Memory Care soiled linen room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Campus Environment, the Director of Environmental Services and the Plant Operations Assistant from 11:40 a.m. to 2:20 p.m. on 06/08/12, the Memory Care soiled linen room had two 32 gallon soiled linen and trash carts stored in the room and the entry door was not equipped</p>	K0029	<p>K 029 Harardous Areas 1. Westminster Village North's technician has installed self-closing devices to each door to the new soiled linen closet on Riley North (memory care) which will cause the door to automaticly close and latch into the door frame. An inspection of other hazardous rooms was conducted to ensure they met the same requirement. No residents were affected. The Plant Operations Manager educated maintenance staff about this code and to the need to always have self-closing devices on all hazardous area doors. Going forward, the Plant Operations Manager will be responsible for ensuring that proper devices are installed on doors to hazardous areas and accoring to Life Safety Code standards. The Plant Operations Manager will work with vendors to make sure the code is followed when changes are made and followed by a final inspection.</p>	07/08/2012

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	<p>with a self closing device which would cause the door to automatically close and latch into the door frame. Based on interview at the time of observation, the Director of Campus Environment and the Director of Environmental Services acknowledged the Memory Care soiled linen room entry door is not equipped with a self closing device which would cause the door to automatically close and latch into the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 11 doors serving hazardous areas such as the kitchen was provided with a positive latching device to latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the the east kitchen entry door from the Riley Dining Room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Campus Environment, the Director of Environmental Services and the Plant Operations Assistant from 11:40 a.m. to 2:20 p.m. on 06/08/12, the east kitchen entry door from the Riley Dining Room is not equipped with a positive latching</p>		<p>The Director of Campus Environment with the Plant Operations Manager will ensure compliance by paying attention to changes made to hazardous area closets or the constructing of new closets. 2. Westminster Village North's technician installed a positive latching device to latch the door into the door frame to the door that goes from the Riley Dining Room to the kitchen. An inspection of the other kitchens was conducted to ensure they meet the same requirement and corrections were made if needed. No residents were affected. The Food Service manager was advised of the need to install a device that will cause the door to latch into the frame. Going forward, the Plant Operations Manager will be responsible for ensuring that proper devices are installed on kitchen doors that latch into the frame of doors that go from dining rooms into kitchens or visa versa according to Life Safety Code standards. The Director of Campus Environment with the Plant Operations Manager will ensure compliance by visually inspecting doors to kitchens. As vendors make requested repairs/replacements, the Plant Operations Manager will advise the vendor of the code requirement.</p>		

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	<p>device to latch the door into the door frame. Based on interview at the time of observation, the Director of Campus Environment and the Director of Environmental Services acknowledged the east kitchen entry door from the Riley Dining Room is not equipped with a positive latching device to latch the door into the door frame.</p> <p>3.1-19(b)</p>				

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K0048 SS=E	<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. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans 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 affects any resident, staff and visitor in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of "Emergency Response Manual: Fire Extinguisher Training Program" documentation during record review with the Director of Campus Environment and the Director of Environmental Services from 9:30 a.m. to 11:40 a.m. on 06/08/12, the facility's</p>	K0048	<p>K 048 Fire Extinguisher Training Program The Director of Campus Environment and Safety Chair added to the Emergency Response Manual and to staff training materials written policies in an effort to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher. Managers were notified of the need to immediately educate staff. No residents were affected. Our goal is to always educate staff on proper emergency techniques and update all training materials when advised of information not in place to comply with Life Safety Code standards. This education will be part of new employee orientation and will be part of the annual Fire Extinguisher education training.</p>	07/08/2012

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	<p>written fire safety plan did not address the use of ABC type fire extinguishers and the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Director of Campus Environment and the Director of Environmental Services acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher.</p> <p>3.1-19(b)</p>			

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K0050 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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 4 of 4 quarters. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on a review of "Fire Report" documentation during record review with the Director of Campus Environment and the Director of Environmental Services from 9:30 a.m. to 11:40 a.m. on 06/08/12, first shift fire drills conducted on 05/31/11, 08/11/11, 09/15/11, 10/12/11, 10/18/11 and 03/28/12 were conducted at between 9:00 a.m. and 10:23 a.m. Based on interview at the time of record review, the Director of Campus Environment and the Director of Environmental Services acknowledged first shift fire drills were not conducted at unexpected times under</p>	K0050	<p>K 050 Fire Drills The Plant Operations Manager and Director of Campus Environment immediately educated staff responsible for conducting the required quarterly fire drills at unexpected times under varying conditions and that the drills must be conducted at random times during the shift. No residents were affected. Going forward, the Plant Operations Manager will be responsible to schedule the required quarterly fire drill times and look at the monthly records to ensure that fire drills are conducted properly and according to Life Safety Code standards of varying times on the 1st shift. The Director of Campus Environment with the Plant Operations Manager will ensure compliance by reviewing the quarterly records to ensure they meet the requirements of varying times according to the Life Safety Code.</p>	07/08/2012			

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	varying conditions. 3.1-19(b)				

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K0051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 133 smoke detectors installed on a ceiling was located not less than four inches from a sidewall. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.4.3 requires spot type smoke detectors shall be located on the ceiling not less than four inches from a sidewall to the near edge or, if on a sidewall, between 4 inches and 12 inches down from the ceiling to the top of the detector. This deficient practice could affect any of resident, staff or visitor in the Woodside Nourishment Room.</p>	K0051	K 051 Smoke Detector The Plant Operations Manager obtained a bid and secured a contractor to relocate the detector so that it is not less than four inches from the sidewall that is located above the Woodside nourishment room. A visual audit was done by maintenance staff to ensure there were no other smoke detectors that were less than four inches from a sidewall. No residents were affected. Going forward, the Plant Operations Manager will be responsible for ensuring that when changes are made that smoke detectors are properly located according to Life Safety Code standards. The Director	07/08/2012
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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Campus Environment, the Director of Environmental Services and the Plant Operations Assistant from 11:40 a.m. to 2:20 p.m. on 06/08/12, a smoke detector installed on the Woodside Nourishment Room ceiling was located less than one half inch from the sidewall of the adjoining pantry room. Based on interview at the time of observation, the Director of Campus Environment and the Director of Environmental Services acknowledged a smoke detector installed on the Woodside Nourishment Room ceiling was located less than four inches from the sidewall of the adjoining pantry room.</p> <p>3-1.19(b)</p>		<p>of Campus Environment with the Plant Operations Manager will ensure compliance by monitoring any physical changes made that would be cause for not being in compliance with this standard.</p>		

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K0064 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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>1. Based on observations and interview, the facility failed to ensure 5 of 15 portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a observations during a tour of the facility with the Director of Campus Environment, the Director of Environmental Services and the Plant Operations Assistant from 11:40 a.m. to 2:20 p.m. on 06/08/12, five fire extinguishers had inspection stickers and collars affixed indicating the most recent six year test was completed in either January 2006 or February 2006. The fire extinguisher's were located by Exit 10, in the Woodside Activity Room, in the Laundry Room soiled side, by Room 511 and by Room 304. Based on interview at the time of the observations, the Director of Campus Environment and the Director of Environmental Services acknowledged</p>	K0064	<p>K 064 Portable Fire Extinguishers 1. The maintenance secretary immediately contacted Koorsen Fire Protection Services to schedule the six year maintenance on the fire extinguishers not in compliance and they have since been completed. Note: according to the service provider, the maintenance of these extinguishers is required to be done in the same year,- not necessarily the same month. the service provider checked all extinguishers campus wide and made corrections to any that were not in compliance. No residents were affected. Going forward, the Plant Operations Manager will be responsible for ensuring that extinguisher maintenance is done according to Life Safety Code standards. This will be done by adding it to the responsibility of the technicians who visually inspect the extinguishers on a monthly basis. The Director of Campus Environment with the Plant Operations Manager will ensure compliance by visually inspecting extinguishers on an ongoing basis so they remain in compliance at all times. The safety committee will be educated in the next meeting on the need to and how to inspect the</p>	07/08/2012			

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	<p>it has been more than six years since the most recent six year test was documented for fire extinguishers in the aforementioned locations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 portable K-class 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 using 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 any staff or visitors in the vicinity of the kitchen.</p> <p>Findings include:</p>		<p>extinguishers on a bi-monthly basis. 2. The Director of Campus Environment affixed a placard above the fire extinguisher that states the fire protection system shall be activated prior to using the fire extinguisher. It also states that the 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. The portable fire extinguisher is supplemental protection. All other kitchens were checked and placards were installed as appropriate. No residents were affected. Our goal is to always educate staff on proper emergency techniques. Future inservices will include the education of placards and how they apply to Life Safety Code standards. The Safety Committee will be educated in the next meeting that when inspecting the fire extinguishers on a bi-monthly basis, to ensure the placards are still in place and to notify the Director of Campus Environment or Safety Chair if there is a need. This will be added to the Safety Committee inspection check list.</p>	

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
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	<p>Based on observation during a tour of the facility with the Director of Campus Environment, the Director of Environmental Services and the Plant Operations Assistant from 11:40 a.m. to 2:20 p.m. on 06/08/12, a placard was not conspicuously placed near the K-class portable fire extinguisher which states the fire protection system shall be activated prior to using the K- class portable fire extinguisher. Based on interview at the time of observation, the Director of Campus Environment acknowledged a placard was not conspicuously placed near the K- class portable fire extinguisher stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher.</p> <p>3.1-19(b)</p>			

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K0000	<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: 06/08/12</p> <p>Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Westminster Village North 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, and 410 IAC 16.2. Building 0103 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. The Administration Wing, identified as Building 0103, built in 2005 was determined to be of Type V (111) construction and fully sprinklered. The</p>	K0000		

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	<p>facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The resident sleeping rooms were provided with battery operated smoke detectors. The facility has a capacity of 123 and had a census of 94 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0050 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 on the first shift for 4 of 4 quarters. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on a review of "Fire Report" documentation during record review with the Director of Campus Environment and the Director of Environmental Services from 9:30 a.m. to 11:40 a.m. on 06/08/12, first shift fire drills conducted on 05/31/11, 08/11/11, 09/15/11, 10/12/11, 10/18/11 and 03/28/12 were conducted at between 9:00 a.m. and 10:23 a.m. Based on interview at the time of record review, the Director of Campus Environment and the Director of Environmental Services acknowledged first shift fire drills were not conducted at unexpected times under</p>	K0050	<p>K 050 Fire Drills The Plant Operations Manager and Director of Campus Environment immediately educated staff responsible for conducting the required quarterly fire drills at unexpected times under varying conditions and that the drills must be conducted at random times during the shift. No residents were affected. Going forward, the Plant Operations Manager will be responsible to schedule the required quarterly fire drill times and look at the monthly records to ensure that fire drills are conducted properly and according to Life Safety Code standards of varying times on the 1st shift. The Director of Campus Environment with the Plant Operations Manager will ensure compliance by reviewing the quarterly records to ensure they meet the requirements of varying times according to the Life Safety Code.</p>	07/08/2012			

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	varying conditions. 3.1-19(b)				