

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304	
(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 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code and Preoccupancy Survey for a Bed Relocation in a new rehabilitation unit of 20 residential T18 beds in rooms C41 to C60 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/09/16</p> <p>Facility Number: 000086 Provider Number: 155170 AIM Number: NA</p> <p>At this Life Safety Code survey Preoccupancy Survey , Westminster Village Muncie Inc was found 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>This one story facility was determined to be of Type V (000) construction and was fully sprinkled. The new Rehabilitation unit was determined to be of Type II (000). It consists of 20 resident dooms, a dining room, a kitchenette, lounge, and a therapy gym. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 76 and had a census of 54 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the kitchen,</p>	K 000		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155170	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304		
(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 000	Continued From page 1 located in the residential portion of the facility. Quality Review on 06/10/16 - DA	K 000			