

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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. 03	<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: 07/06/16</p> <p>Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530</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> <p>This one story facility was determined to be of Type II (000) construction and fully</p>	K 0000	<p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission to liability and such liability here in denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings or constitute a deficiency, or that the scope and severity regarding any of the areas being cited correctly. Please accept this Plan of Correction as our credible allegation of compliance. We request a desk review for this survey</p>	
------------------------	---	--------	---	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/06/2016	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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 0050 SS=C Bldg. 03	<p>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 89 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 completed on 07/08/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 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 third shift for 4 of 4</p>	K 0050	<p>1. Maintenance director will conduct Fire Drills on Third shift at varying times and conditions in accordance with Life Safety Code Standard</p> <p>2 This will effect all residents in</p>	07/14/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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 0062 SS=F Bldg. 03	<p>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 9:00 a.m. to 12:00 p.m. on 07/06/16, third shift fire drills conducted on 09/21/15, 12/09/15, 03/31/16 and 06/14/16 were conducted at, respectively, 5:00 a.m., 4:00 a.m., 4:30 a.m. and 5:00 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13,</p>		<p>building</p> <p>3 Drills have been scheduled for the next year on Third shift as follows: 9/22/14 @ 2:00 Am, 12/9/16 @ 4:00 AM, 3/30/17 @ 6:00 AM, and 6/13/17 @ 11:00 PM. All other shifts will also be monitored by Maintenance Director for varying times and presented to Quality Assurance Committee for review</p> <p>4. Yearly schedule will be brought to Quality Assurance Committee for approval to insure varying times on all shifts. Administrator will approve yearly schedule at January Quality Assurance Meeting</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
	<p>NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure all private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:00 a.m. to 12:00 p.m. on 07/06/16, documentation of fire hydrant inspection for all facility fire hydrants within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the local fire department flushes facility fire hydrants on the premises on an annual basis but acknowledged documentation of facility owned fire hydrant inspections within the most recent twelve month period was not available for review. Based on</p>	K 0062	<p>1. Maintenance Director contacted Fire Marshall from Wayne Township Fire Department for demonstration of Hydrant inspection and flow test and test was performed on 7/14/16.</p> <p>2. Would affect all residents at Westside.</p> <p>3. Maintenance Director has set this as a part of our yearly flow test with our current contractor, Koorson, and will be done every August.</p> <p>4. Results of test will be presented to the Quality Assurance for review and validation test was performed.</p>	07/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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 0076 SS=E Bldg. 03	<p>observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:20 p.m. on 07/06/16, one facility owned fire hydrant was noted on the premises at the rear of the facility near the exit by Room 209.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart in the Oxygen Storage and Transfilling Room near Room 319. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires</p>	K 0076	<p>1 Maintenance Director purchased rack for storage of cylinders in Oxygen storage room near resident room 319</p> <p>2 Twenty (20) residents in the section of the facility where deficiency was cited could be affected</p> <p>3 Maintenance on daily rounds will monitor for proper storage of oxygen tanks, and correct storage as needed.</p>	07/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/06/2016	
NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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 0147 SS=E Bldg. 03	<p>freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Oxygen Storage and Transfilling Room near Room 319.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:20 p.m. on 07/06/16, one 'E' type oxygen cylinder was freestanding on the floor in the Oxygen Storage and Transfilling Room near Room 319 without support. Based on interview at the time of observation, the Maintenance Director acknowledged the 'E' type oxygen cylinder was freestanding and was not properly chained or supported in a proper cylinder stand or cart.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 extension</p>	K 0147	<p>4. Findings will be corrected immediately (if needed) and reported to Quality Assurance Committee for review and further steps to be taken if necessary.</p> <p>1 Maintenance Director immediately removed power strip</p>	07/14/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
	<p>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. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 20 residents, staff and visitors in the vicinity of Room 314.</p> <p>Findings include:</p>		<p>and phone power cord in room 314 2 Potentially affect all residents 3 On daily (Monday thru Friday) rounds, Maintenance will randomly check 3 rooms on each unit for potential usage of power strips near beds Maintenance will also check rooms of new admissions for proper usage of outlets 4 Findings will be reported to monthly, and as needed, to the Quality Assurance Committee for review and interventions as needed</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155606	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WESTSIDE RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 8616 W 10TH ST INDIANAPOLIS, IN 46234
---	---

(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
	<p>Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:20 p.m. on 07/06/16, a telephone charger was plugged into a power strip on the floor underneath the resident bed in Room 314. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring underneath the resident bed in Room 314.</p> <p>3.1-19(b)</p>			