

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 10/27/2014
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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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K010000	<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: 10/27/14</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 Inc. 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 with a partial basement was surveyed as five separate buildings due to the construction dates of five sections of the building. Building 0101, which consists of Willow Commons, Heatherwood Commons,</p>	K010000		

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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K010025 SS=E	<p>Aspen Commons and Juniper Commons, was built in 1974 and was determined to be of Type V (111) 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. Building 0101 resident sleeping rooms were provided with smoke detectors hard wired to the fire alarm system. The facility has a capacity of 148 and had a census of 116 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/07/14.</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 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in</p>			

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	<p>duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Heatherwood Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, two openings were noted in the ceiling smoke barrier above the electrical panel in the Heatherwood Mechanical Room which failed to maintain the smoke resistance of the ceiling smoke barrier. The first opening</p>	K010025	<p>1. Base on observation and interview the facility failed to ensure doors in 1 of 4 attic smoke barrier walls were locked or latched to maintain the one hour fire resistance rating of the smoke barrier in Aspen Commons Attic. Please note that no residents were affected. Immediately following the inspection, contractor was contacted and work scheduled to make necessary repairs as to assure the door latches into the frame. The contractor made necessary repairs to the door and latch as to assure that the fire door remains closed and latched into the frame at all times which allows the area to maintain the one hour fire resistant rating of the smoke barrier. (The document of completion is attached.) Going forward the Director of Plant Operations will assure compliance by adding to the monthly maintenance schedule to make sure the attic door continues to remain latched into the frame. An Electronic work request has been entered in Worxhub that will generate a request for the Maintenance Technician monthly to complete (Work requests is attached). On a monthly basis the Director of Plant Operations will review the work order to assure compliance.</p>	11/20/2014

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	<p>in the ceiling was two inches in diameter for the passage of four cables and the second opening in the ceiling was one inch in diameter for the passage of one cable. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned openings in the Heatherwood Mechanical Room failed to maintain the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>On a monthly basis the Director of Campus Environment and Compliance will review and maintain documents as another tier of the process to assure compliance. The Director of Plant Operations will report the status of the inspections at the monthly Quality Assurance meetings for at least six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100% compliance. 2. Based on observation and interview, the facility failed to ensure openings in 1 of 15 smoke barriers were protected to maintain the smoke resistance of the smoke barrier wall above the suspended ceiling at the corridor door set by Room 3273 in Cedar Commons. Please note that no residents were affected. Immediately following the inspection, contractors were notified and work scheduled to fill the two holes above the electrical panel with fire stop to ensure the ceiling will maintain the smoke barrier. As a second layer of compliance, WVN Maintenance Technician was also assigned the duty and work completed. (Work order #38127 attached). Going forward, the Director of Plant Operations will be responsible for ensuring that penetrations are filled according to Life Safety Code standards following work done by WVN Technicians and/or</p>	

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review, observation and interview; the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 3 of 3 emergency generators. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency</p>	K010144	<p>outside vendors. He will monitor to make sure smoke stop is applied when running lines or cables through drywall to maintain the smoke resistance of the smoke barrier according to requirement.</p> <p>Based on record review, observations and interview; the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 3 of 3 emergency generators. At the time of the inspection, all other documentation was reviewed showing that the required monthly inspection occurred per the standard. At the time of the inspection, all three generators were tested to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss and was found to be in compliance. Please note that no residents were affected. Going forward, the Director of Plant Operations will assure that on a monthly basis the information is documented on the monthly check sheet. Electronic work requests have been entered in Worxhub that will generate a</p>	11/20/2014

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	<p>Generator-30 Minute Monthly Test Log" documentation with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during record review from 9:45 a.m. to 12:00 p.m. on 10/27/14, documentation for emergency power transfer time for the eight month period of February 2014 through September 2014 for each of three emergency generators serving the facility was not available for review. Based on interview at the time of record review, the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant stated no additional generator transfer time documentation for emergency power transfer time was available for review and acknowledged emergency power transfer time was not documented for the eight month period of February 2014 through September 2014 for each of three emergency generators serving the facility. Based on observations with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, power was transferred to each of the three emergency generators in less than ten seconds when each transfer switch was tested.</p>		<p>request to have the Maintenance Technician to complete the test on a monthly basis and document the number of seconds it takes for the power to be transferred to emergency power (3 electronic Work requests attached). On a monthly basis the Director of Plant Operations will review the document to assure compliance. The Director of Campus Environment and Compliance will review and maintain documents monthly as another tier of the process to assure compliance. The Director of Plant Operations will report the status of the inspections at the monthly Quality Assurance meetings for at least six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100% compliance.</p>	

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K030000	<p>3.1-19(b)</p> <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: 10/27/14</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 Inc. 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. Buildings 0103, 0105, 0106 and 0107 were surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility with a partial basement was surveyed as five separate</p>	K030000		

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	<p>buildings due to the construction dates of five sections of the building. The Administration Wing, identified as Building 0103, was built in 2005 and was determined to be of Type V (111) construction and fully sprinklered. Cedar Commons, identified as Building 0105 and Aspen Commons, identified as Building 0106 were each built in 2013 and were determined to be of Type V (111) construction and fully sprinklered. The new Dining Room, kitchen and walkway addition to Memory Care, identified as Building 0107, was built in 2014 and was determined to be of Type V (111) 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. Building 0105 and Building 0106 resident sleeping rooms were provided with smoke detectors hard wired to the fire alarm system. The facility has a capacity of 148 and had a census of 116 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/07/14.</p>			

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K050000	<p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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: 10/27/14</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 Inc. 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. Buildings 0103, 0105, 0106 and 0107 were surveyed with Chapter 18, New Health Care</p>	K050000		

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	<p>Occupancies.</p> <p>This one story facility with a partial basement was surveyed as five separate buildings due to the construction dates of five sections of the building. The Administration Wing, identified as Building 0103, was built in 2005 and was determined to be of Type V (111) construction and fully sprinklered. Cedar Commons, identified as Building 0105 and Aspen Commons, identified as Building 0106 were each built in 2013 and were determined to be of Type V (111) construction and fully sprinklered. The new Dining Room, kitchen and walkway addition to Memory Care, identified as Building 0107, was built in 2014 and was determined to be of Type V (111) 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. Building 0105 and Building 0106 resident sleeping rooms were provided with smoke detectors hard wired to the fire alarm system. The facility has a capacity of 148 and had a census of 116 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p>			

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K050025 SS=E	<p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/07/14.</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 Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure doors in 1 of 4 attic smoke barrier walls were locked or latched to maintain the one hour fire resistance rating of the smoke barrier. LSC 8.2.3.2.1 states door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 80, 1999 edition, section 2-1.2 states a fire door assembly shall include a lock or a latch. Section</p>	K050025	<p>1. Base on observation and interview the facility failed to ensure doors in 1 of 4 attic smoke barrier walls were locked or latched to maintain the one hour fire resistance rating of the smoke barrier in Aspen Commons Attic. Please note that no residents were affected. Immediately following the inspection, contractor was contacted and work scheduled to make necessary repairs as to assure the door latches into the frame. The contractor made necessary repairs to the door and latch as to assure that the fire</p>	11/20/2014

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	<p>2-1.4 states all swinging doors shall be closed and latched at the time of fire. This deficient practice could affect 15 residents staff and visitors in Aspen Commons.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, the latching mechanism in the one hour rated fire door in the Aspen Commons attic smoke barrier wall above Room 3200 failed to latch the door into the door frame when tested five separate times. The door was not equipped with a lock and the latching mechanism failed to protrude into the door frame. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned one hour fire rated door in the Aspens Common attic smoke barrier wall failed to latch into the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings in 1 of 15 smoke barriers were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service</p>		<p>door remains closed and latched into the frame at all times which allows the area to maintain the one hour fire resistant rating of the smoke barrier. (The document of completion is attached.) Going forward the Director of Plant Operations will assure compliance by adding to the monthly maintenance schedule to make sure the attic door continues to remain latched into the frame. An Electronic work request has been entered in Worxhub that will generate a request for the Maintenance Technician monthly to complete (Work requests is attached). On a monthly basis the Director of Plant Operations will review the work order to assure compliance. On a monthly basis the Director of Campus Environment and Compliance will review and maintain documents as another tier of the process to assure compliance. The Director of Plant Operations will report the status of the inspections at the monthly Quality Assurance meetings for at least six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100%compliance. 2. Based on observation and interview, the facility failed to ensure openings in 1 of 15 smoke barriers were protected to maintain the smoke resistance of the smoke barrier wall above the suspended ceiling</p>	

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	<p>materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 12 residents, staff or visitors in the vicinity of the smoke barrier wall near Room 3273 in Cedar Commons.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, the smoke barrier wall above the suspended ceiling at the corridor door set by Room 3273 in Cedar Commons had two one inch in diameter holes for the passage of two cables which passed through the wall and was not firestopped. Based on interview at the time of observation, the Maintenance Assistant acknowledged the aforementioned smoke barrier openings were not firestopped to maintain the smoke resistance of the smoke barrier.</p> <p>3.1-19(b)</p>		<p>at the corridor door set by Room 3273 in Cedar Commons. Please note that no residents were affected. Immediately following the inspection, contractors were notified and work scheduled to fill the two holes above the electrical panel with fire stop to ensure the ceiling will maintain the smoke barrier. As a second layer of compliance, WVN Maintenance Technician was also assigned the duty and work completed. (Work order #38127 attached). Going forward, the Director of Plant Operations will be responsible for ensuring that penetrations are filled according to Life Safety Code standards following work done by WVN Technicians and/or outside vendors. He will monitor to make sure smoke stop is applied when running lines or cables through drywall to maintain the smoke resistance of the smoke barrier according to requirement.</p>	

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K060000	<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: 10/27/14</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 Inc. 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</p>	K060000		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 06 B. WING _____	X3) DATE SURVEY COMPLETED 10/27/2014
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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>Protection Association (NFPA) 101, and 410 IAC 16.2. Buildings 0103, 0105, 0106 and 0107 were surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility with a partial basement was surveyed as five separate buildings due to the construction dates of five sections of the building. The Administration Wing, identified as Building 0103, was built in 2005 and was determined to be of Type V (111) construction and fully sprinklered. Cedar Commons, identified as Building 0105 and Aspen Commons, identified as Building 0106 were each built in 2013 and were determined to be of Type V (111) construction and fully sprinklered. The new Dining Room, kitchen and walkway addition to Memory Care, identified as Building 0107, was built in 2014 and was determined to be of Type V (111) 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. Building 0105 and Building 0106 resident sleeping rooms were provided with smoke detectors hard wired to the fire alarm system. The facility has a capacity of 148 and had a census of 116 at the time of this survey.</p>			

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K060020 SS=E	<p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/07/14.</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 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1.</p> <p>An atrium may be used in accordance with 8.2.2.3.5.</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 attic access vertical openings were protected as appropriate for the fire resistance rating of the barrier. LSC 18.3.1.2 states doors in a stair enclosure shall be self closing and shall normally be kept in the closed position. This deficient practice could affect 54 residents, staff and visitors in Aspen Commons and Cedar Commons if smoke from a fire were to infiltrate the</p>	K060020	Based on observation and interview, the facility failed to ensure 4 of 4 attic access vertical openings were protected as appropriate for fire resistance rating of the barrier. During the inspection at the time of discovery, each of the affixed folding metal staircases were folded and pushed up into the attic access allowing the attic to then be protected as appropriate for the fire resistance rating of the	11/20/2014

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	<p>protective barriers.</p> <p>Findings include:</p> <p>Based on observations with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, the two attic access doors in Aspen Commons ceiling smoke barrier and the two attic access doors in the Cedar Commons ceiling smoke barrier were observed in the fully open position which did not protect the vertical openings as appropriate for the fire resistance rating of the barrier. Each of the attic access doors were provided with an affixed folding metal staircase which was in the fully open position to allow easy access to the attic. Based on interview at the time of the observations, the Maintenance Assistant stated the access doors are always kept in the fully open position because of the weight of the access door and folding metal staircase assembly and acknowledged each attic access vertical opening was not protected as appropriate for the fire resistance rating of the barrier when allowed to remain open when not in use.</p> <p>3.1-19(b)</p>		<p>barrier. Please note that no residents were affected. Immediate action was taken following the inspection. An 11 X 17, laminated red and yellow signage was made and mounted on the wall and in direct view when door to attic access room is opened. It will serve as a reminder that the stairs must be folded up and placed in the closed position into the attic opening (Sign Attached).The Director of Plant Operations gave an education session to all maintenance staff that under no circumstances are any of the attic access pull down stairs to be left down and must be retracted back into the ceiling (Inservice document with signatures attached). The Director of Plant Operations gave the same inservice to the current project management company team leaders. (Inservice document with signatures attached). Going forward the Director of Plant Operations will assure compliance by adding to the weekly maintenance schedule to make sure stairs remain in the closed position. Electronic work requests have been entered in Worxhub that will generate a request for the Maintenance Technician to complete(Work requests #38302 & #38484 attached). Also the check sheet used to inspect Random Daily Health Center Hazardous Material Closet Locked Door</p>	

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K060061 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV) serving Aspen Commons. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler</p>	K060061	<p>Check is also used for this purpose (check sheet attached). On a weekly basis the Director of Plant Operations will review the completed work request and document to assure compliance. On a monthly basis the Director of Campus Environment and Compliance will review and maintain documents as another tier of the process to assure compliance. The Director of Plant Operations will report the status of the inspections at the monthly Quality Assurance meetings for at least six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100% compliance.</p> <p>Based on observation and interview, the facility failed to electronically supervise 1 of 1 Post Indicator Valves (PIV) serving Aspen Commons. Please note that no residents were affected. Immediately following the inspection, the Director of Plant Operations purchased a padlock to lock the Aspen Commons PIV lever to keep it from being turned and tampered with. Subsequently, an audit of all PIV's was made</p>	11/20/2014

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K060064 SS=D	<p>system. This deficient practice could affect 30 residents, staff and visitors in Aspen Commons if the water to the sprinkler system was shut off and not detected due to lack of supervision.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, the PIV located outside of the kitchen by Aspen Commons was not mechanically secured and lacked electronic supervision. Based on interview at the time of observation, the Director of Plant Operations stated the PIV serves the Aspen Commons automatic sprinkler system and acknowledged the PIV was not mechanically secured and lacked electronic supervision.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the</p>	K060064	<p>campus wide and they too were padlocked to keep the lever from being turned and tampered with. (Work order #38124 attached and pad lock purchase).</p> <p>Following the official Life Safety Code report received 11-10-14, contractors were notified to give an estimate and schedule the installation of a supervisory attachment that will monitor the integrity in accordance with NFPA72 and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of sprinkler system.</p> <p>(Confirmation email attached)</p> <p>Going forward, the Director of Plant Operations will be responsible for making sure any new PIV's installed are fitted with a supervisory attachment that will monitor the integrity in accordance with NFPA72 and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of sprinkler system.</p> <p>Based on observation and interview, the facility failed to</p>	11/20/2014			

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	<p>facility failed to inspect 1 of over 20 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect two staff and visitors in the vicinity of the basement elevator machine room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, the inspection tag affixed to the portable fire extinguisher located in the basement elevator machine room lacked documentation of a monthly inspection for December 2013 through</p>		<p>inspect 1 of over 20 portable fire extinguishers each month located in Cedar Commons elevator service room. At the time of the inspection, the fire extinguisher was replaced with an extinguisher that had been checked on a monthly basis and within code requirements. Please note that no residents were affected. Going forward, the Director of Plant Operations will be responsible for making sure all fire extinguishers are checked on a monthly basis per code requirements. An Electronic work requests has been entered in Worxhub that will generate a request for the Maintenance Technician to complete on a monthly basis, a visual inspection of the fire extinguisher to ensure the fire extinguisher is available and will operate since the intent is to give reasonable assurance that the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. (Work orders attached). A map document has been prepared that shows the location of each and every fire extinguisher in the health center and subsequently campus wide to assure that each extinguisher gauge remains in the green zone and operational should the need arise. (Maps attached) Going forward, the</p>	

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K060144 SS=C	<p>September 2014. Based on interview at the time of observation, the Maintenance Assistant stated additional fire extinguisher monthly check documentation was not available for review and acknowledged the aforementioned fire extinguisher lacked documentation of a monthly inspection for December 2013 through September 2014.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review, observation and interview; the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 3 of 3 emergency generators. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency</p>	K060144	<p>Director of Plant Operations will be responsible for ensuring that fire extinguishers are checked on a monthly basis according Life Safety Code standards by review the work order status and the map provided to assure compliance. On a monthly basis the Director of Campus Environment and Compliance will review and maintain documents as another tier of the process to assure compliance. The Director of Plant Operations will report the status of the inspections at the monthly Quality Assurance meetings for at least six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100% compliance.</p> <p>Based on record review, observations and interview; the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 3 of 3 emergency generators. At the time of the inspection, all other documentation was reviewed showing that the required monthly inspection occurred per the standard. At the time of the</p>	11/20/2014

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	<p>system within 10 seconds after loss of normal power. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator-30 Minute Monthly Test Log" documentation with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during record review from 9:45 a.m. to 12:00 p.m. on 10/27/14, documentation for emergency power transfer time for the eight month period of February 2014 through September 2014 for each of three emergency generators serving the facility was not available for review. Based on interview at the time of record review, the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant stated no additional generator transfer time documentation for emergency power transfer time was available for review and acknowledged emergency power transfer time was not</p>		<p>inspection, all three generators were tested to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss and was found to be in compliance. Please note that no residents were affected. Going forward, the Director of Plant Operations will assure that on a monthly basis the information is documented on the monthly check sheet. Electronic work requests have been entered in Worxhub that will generate a request to have the Maintenance Technician to complete the test on a monthly basis and document the number of seconds it takes for the power to be transferred to emergency power (3 electronic Work requests attached). On a monthly basis the Director of Plant Operations will review the document to assure compliance. The Director of Campus Environment and Compliance will review and maintain documents monthly as another tier of the process to assure compliance. The Director of Plant Operations will report the status of the inspections at the monthly Quality Assurance meetings for at least six months. At the end of six months the QA team may choose to cease the monthly review of these audits if the audits reveal 100% compliance.</p>	

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K070000	<p>documented for the eight month period of February 2014 through September 2014 for each of three emergency generators serving the facility. Based on observations with the Director of Campus Environmental Compliance, the Director of Plant Operations and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 4:20 p.m. on 10/27/14, power was transferred to each of the three emergency generators in less than ten seconds when each transfer switch was tested.</p> <p>3.1-19(b)</p> <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: 10/27/14</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 Inc. was</p>	K070000		

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	<p>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. Buildings 0103, 0105, 0106 and 0107 were surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility with a partial basement was surveyed as five separate buildings due to the construction dates of five sections of the building. The Administration Wing, identified as Building 0103, was built in 2005 and was determined to be of Type V (111) construction and fully sprinklered. Cedar Commons, identified as Building 0105 and Aspen Commons, identified as Building 0106 were each built in 2013 and were determined to be of Type V (111) construction and fully sprinklered. The new Dining Room, kitchen and walkway addition to Memory Care, identified as Building 0107, was built in 2014 and was determined to be of Type V (111) 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. Building 0105 and Building 0106 resident sleeping rooms were</p>			

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	<p>provided with smoke detectors hard wired to the fire alarm system. The facility has a capacity of 148 and had a census of 116 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/07/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				