

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2015
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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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K 0000 Bldg. 01	<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: 12/30/15</p> <p>Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600</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 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, Aspen Commons and Juniper Commons, was built in 1974 and was determined to be of Type V (111) construction and fully</p>	K 0000		

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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K 0050 SS=F Bldg. 01	<p>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 126 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 completed 01/05/16 - DA</p> <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 Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in</p>	K 0050	A fire drill report was not available for review for the 2ndquarter (April, May, and June 2015) on the 2nd Shift. This resulted in 5 K0050 tags due to the buildingsbeing considered separated- 01, 03, 05, 06, and 07.	01/29/2016

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K 0062 SS=D Bldg. 01	<p>the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Report: Fire" with the Director of Campus Environment and the Director of Plant Operations during record review from 9:30 a.m. to 12:00 p.m. on 12/30/15, documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) of 2015 was not available for review. Based on interview at the time of record review, the Director of Campus Environment acknowledged documentation of a fire drill conducted on the second shift in the aforementioned quarter was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 1 of over 100</p>	K 0062	<p>1. Work orders have been entered in Worxhub (electronic work order program) that will be generated on a monthly basis to perform fire drill on the 2nd Shift and an electronic response will be generated once complete. (copy attached)</p> <p>2. During audits, no residents were found to be harmed.</p> <p>3. On a monthly basis, the Dir. of Plant Operations will complete a check sheet making sure he has received the completed Fire Drill reports from nurse stations following a fire drill. (copy attached log)</p> <p>4. Director of Plant Operations will report in monthly QA meetings any problems or concerns and supporting documentation will be given to Dir. of Campus Environment and Compliance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthly audits, if the audits reveal 100% compliance.</p> <p>Sprinkler gauges on the sprinkler riser in Administrative Wing</p>	01/29/2016
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	<p>sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect two staff and visitors in the vicinity of the Juniper Commons Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environment and the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, the sidewall sprinkler installed under the building exterior canopy outside the Juniper Commons Mechanical Room was green with corrosion. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned sprinkler location had become green with corrosion and should be replaced.</p> <p>3.1-19(b)</p>		<p>electrical room had a manufacture date of 2009. It was out of compliance for the 5 year replacement or recalibrating.</p> <p>1. Following the survey, WVN's maintenance technician purchased and replaced the outdated 2009 gauge as well as the 2010 gauge. (see attached work order and photos)</p> <p>2. An audit was completed and corrections were made of other gauges if needed. (see attached work order).</p> <p>3. During an audit, no residents were found to be harmed.</p> <p>4. A work order has been entered in Worxhub (electronic work order program) that will be generated on an ANNUAL basis in October to check and replace any gauge that is not within the 5 year requirement. (see attached work order)</p>	

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K 0144 SS=F Bldg. 01	<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 observation and interview, the facility failed to ensure 1 of 3 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect 60 residents, staff and visitors in Juniper Commons and Heatherwood Commons.</p>	K 0144	<p>The 3 Generators (Aspen/Willow; Heatherwood/Juniper; CedarCommons) were found that they lacked a remote shut off device.</p> <p>1. Following the inspection, Turner Construction was notified to assist in getting bids to install a remote shut off device for each generator.</p> <p>2. During an audit, no residents were found to be affected.</p> <p>3. A meeting with Ermco Electric, Turner Construction and Dir. of Plant Operations on Thursday, Jan. 14, 2016 and waiting for estimate to install. (see attached)</p> <p>4. Going forward, when a new generator is installed, the Director of Plant Operations make sure that the installers are made aware that a remote shut off is required and installed according to NFPA 110, Standard for Emergency and Standby Power Systems from the NFPA 110, 1999 edition, 3-5.5.6 per requirements.</p>	01/29/2016

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K 0147 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Director of Campus Environment and the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, the 175 kW emergency generator located outside the Juniper Commons Mechanical Room lacked a remote shut off device. Based on interview at the time of the observation, the Director of Plant Operations acknowledged there was no remote shut off device for the aforementioned emergency generator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring.</p>	K 0147	Heatherwood Electrical Room in Activity Room – storage in front of transfer switch has been left there by activities staff.	01/29/2016
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	<p>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. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Willow Commons Lounge.</p> <p>Findings include:</p> <p>Based on observations with the Director of Campus Environment during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, the following was noted:</p> <p>a. a coffee pot and a refrigerator were plugged into a power strip in the Willow Commons Activities Office.</p> <p>b. a coffee pot was plugged into a power strip in the Willow Commons Concierge Office.</p> <p>Based on interview at the time of the observations, the Director of Campus Environment acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned two locations which are next to the Willows Commons Lounge.</p> <p>3.1-19(b)</p>		<p>1.A discussion with the Manager of Health CenterActivities took place to educate the activity staff on proper storage ofactivity supplies. Manager educatedactivity staff on proper storage of activity supplies to be other than front oftransfer switch in Electrical room. (see attached)</p> <p>2.During an audit, no residents were found to be harmed.</p> <p>3.The room was cleaned and items that were improperly storedwere moved.</p> <p>The Manager of Health Center Activities will monitorthe closet and will report in monthly QA meetings any problems or concerns andsupporting documentation will be given to Dir. of Campus Environment andCompliance for 6 months. At the end ofthe 6 months, the QA team may choose to cease the monthly audits, if the auditsreveal 100% compliance</p>		

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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: 12/30/15</p> <p>Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600</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. 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</p>	K 0000		

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K 0050 SS=F Bldg. 03	<p>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 126 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 completed 01/05/16 - DA</p> <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</p>			

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	<p>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 document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Report: Fire" with the Director of Campus Environment and the Director of Plant Operations during record review from 9:30 a.m. to 12:00 p.m. on 12/30/15, documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) of 2015 was not available for review. Based on interview at the time of record review, the Director of Campus Environment acknowledged documentation of a fire drill conducted on the second shift in the aforementioned quarter was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>A fire drill report was not available for review for the 2ndquarter (April, May, and June 2015) on the 2nd Shift. This resulted in 5 K0050 tags due to the buildingsbeing considered separated- 01, 03, 05, 06, and 07.</p> <p>1.Work orders have been entered in Worxhub (electronicwork order program) that will be generated on a monthly basis to perform firedrill on the 2nd Shift and an electronic response will be generatedonce complete. (copy attached)</p> <p>2.During audits, no residents were found to be harmed.</p> <p>3.On a monthly basis, the Dir. of Plant Operations willcomplete a check sheet making sure he has received the completed Fire Drillreports from nurse stations following a fire drill. (copy attached log)</p> <p>4.Director of Plant Operations will report in monthly QA meetingsany problems or concerns and supporting documentation will be given to Dir. ofCampus Environment and Compliance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthlyaudits, if the audits reveal</p>	01/29/2016

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K 0062 SS=D Bldg. 03	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect five staff and visitors in the Administration Wing.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environment during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, one of two sprinkler system gauges at the sprinkler system riser location in the Administration Wing electrical room had a manufacture date of 2009. No recalibration documentation was affixed to the aforementioned sprinkler system gauge. Based on interview at the time of observation, the</p>	K 0062	<p>100% compliance.</p> <p>Sprinkler gauges on the sprinkler riser in AdministrativeWing electrical room had a manufacture date of 2009. It was out of compliance for the 5 yearreplacement or recalibrating.</p> <p>1. Following the survey, WVN's maintenance technicianpurchased and replaced the outdated 2009 gauge as well as the 2010 gauge. (seeattached work order and photos)</p> <p>2. An audit was completed and corrections were made ofother gauges if needed. (see attached work order).</p> <p>3. During an audit, no residents were found to be harmed.</p> <p>4. A work order has been entered in Worxhub (electronicwork order program) that will be generated on an ANNUAL basis in October to checkand replace any gauge that is not within the 5 year requirement. (see attached work order)</p>	01/29/2016

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K 0000 Bldg. 05	<p>Director of Campus Environment stated recalibration documentation for the aforementioned sprinkler system gauge was not available for review and acknowledged the Administration Wing electrical room sprinkler system gauge had a manufacture date of 2009 which exceeded the five year requirement for recalibration or replacement.</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: 12/30/15</p> <p>Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600</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</p>	K 0000		

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	<p>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 provided with smoke detectors hard wired to the fire alarm system. The facility has a capacity of 148 and had a census of 126 at the time of this survey.</p>			

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K 0046 SS=E Bldg. 05	<p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed 01/05/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review, observation, and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 1 of 3 battery operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a 30 second functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 14 residents, staff and visitors in Cedar Commons.</p>	K 0046	<p>1. In the Loggia corridor, the two battery powered emergency lighting systems were not tested on a monthly and annual basis.</p> <p>1. Turner Construction was contacted and with the assistance of Gaylor Electric, to determine the purpose of the additional lighting since there is already emergency hallway lighting in corridors. It was determined that the battery pack lights were provided in order to attain the 1 ft-candle lighting for the means of egress pathway in the event of a power failure and will remain in place.</p> <p>2. During audits, no residents were found to be harmed.</p> <p>3. A "monthly 30 second test" was added to the already in place monthly sprinkler visual inspection PM work order. The "annual 90 minutes" test was added to the Cedar Commons</p>	01/29/2016

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	<p>Findings include:</p> <p>Based on review of "Emergency Generator - Cedar Commons" documentation for the twelve month period of 01/05/15 to 12/29/15 with the Director of Campus Environment and the Director of Plant Operations from 9:30 a.m. to 12:00 p.m. on 12/30/15, documentation of monthly functional testing and annual testing for the battery powered emergency lighting system located at the Cedar Commons emergency generator was not available for review. The aforementioned documentation under the "Battery Operated Light" section listed a checkmark for each month the light was tested but did not indicate what type of test was conducted. Based on observation with the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, one battery powered emergency lighting system was located at the Cedar Commons emergency generator and the light functioned when its respective test button was pushed. Based on interview at the time of record review and of observation, the Director of Plant Operations acknowledged monthly and annual functional testing documentation for the aforementioned battery operated emergency light for the most recent</p>		<p>Emergency Generator Check Sheet to be performed at the same time. (see attached work order and check sheet)</p> <p>4. Education of safety committee was completed on 1-13-16a detailing the added duties as part of their inspection check sheet focusing on this infraction. (see attached)</p> <p>5. Bi-monthly – Safety inspection reports will be given to Dir. of Campus Environment and Compliance. (see attached check sheet)</p> <p>6. Director of Plant Operations will monitor check sheet and will report in monthly QA meetings any problems or concerns and supporting documentation will be given to Dir. of Campus Environment and Compliance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthly audits, if the audits reveal 100% compliance.</p>	

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K 0050 SS=F Bldg. 05	<p>twelve month period was not available for review.</p> <p>3.1-19(b)</p> <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 document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Report: Fire" with the Director of Campus Environment and the Director of Plant Operations during record review from 9:30 a.m. to 12:00 p.m. on 12/30/15, documentation of a fire drill conducted on the second shift in the second quarter</p>	K 0050	<p>A fire drill report was not available for review for the 2ndquarter (April, May, and June 2015) on the 2nd Shift. This resulted in 5 K0050 tags due to the buildingsbeing considered separated- 01, 03, 05, 06, and 07.</p> <p>1.Work orders have been entered in Worxhub (electronicwork order program) that will be generated on a monthly basis to perform firedrill on the 2nd Shift and an electronic response will be generatedonce complete. (copy attached)</p> <p>2.During audits, no residents were found to be harmed.</p> <p>3.On a monthly basis, the Dir. of Plant Operations willcomplete a check sheet</p>	01/29/2016

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K 0144 SS=F Bldg. 05	<p>(April, May, June) of 2015 was not available for review. Based on interview at the time of record review, the Director of Campus Environment acknowledged documentation of a fire drill conducted on the second shift in the aforementioned quarter was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</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.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the</p>	K 0144	<p>making sure he has received the completed Fire Drillreports from nurse stations following a fire drill. (copy attached log)</p> <p>4. Director of Plant Operations will report in monthly QA meetings any problems or concerns and supporting documentation will be given to Dir. of Campus Environment and Compliance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthly audits, if the audits reveal 100% compliance.</p> <p>The 3 Generators (Aspen/Willow; Heatherwood/Juniper; Cedar Commons) were found that they lacked a remote shut off device.</p> <p>1. Following the inspection, Turner Construction was notified to assist in getting bids to install a remote shut off device for each generator.</p> <p>2. During an audit, no residents were found to be affected.</p> <p>3. A meeting with Ermco Electric, Turner Construction and Dir. of Plant Operations on Thursday, Jan. 14, 2016 and waiting for estimate to install. (see attached)</p> <p>4. Going forward, when a new generator is installed, the Director</p>	01/29/2016

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K 0147 SS=E Bldg. 05	<p>building. This deficient practice could affect 24 residents, staff and visitors in Cedar Commons.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environment and the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, the 150 kW emergency generator located outside Cedar Commons lacked a remote shut off device. Manufacturer's information affixed to the nameplate of the emergency generator indicated the unit was manufactured 03/15/13. Based on interview at the time of observation, the Director of Plant Operations stated the emergency generator was installed after 2003 and acknowledged there was no remote shut off device for the aforementioned emergency generator.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the</p>	K 0147	<p>of Plant Operations make sure that the installers are made aware that a remote shut off is required and installed according to NFPA 110, Standard for Emergency and Standby Power Systems from the NFPA 110, 1999 edition, 3-5.5.6per requirements.</p> <p>Heatherwood Electrical Room in Activity Room – storage in front of</p>	01/29/2016	

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	<p>facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 3 main electrical rooms. NFPA 70, Article 110-26(a) states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of Article 110-26(a)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110-26(b) states the working space required by this section shall not be used for storage. This deficient practice could affect 24 residents, staff and visitors in Cedar Commons.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environment and the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, seven cardboard boxes filled with microwave oven cooking supplies were stored up against the emergency generator transfer switch for Cedar Commons in the electrical room in the Heatherwood Commons Activities Room. In addition, one plastic bin filled with bird seed, one bag of bird seed and</p>		<p>transfer switch has been left there by activities staff.</p> <p>1.A discussion with the Manager of Health CenterActivities took place to educate the activity staff on proper storage ofactivity supplies. Manager educatedactivity staff on proper storage of activity supplies to be other than front oftransfer switch in Electrical room. (see attached)</p> <p>2.During an audit, no residents were found to be harmed.</p> <p>3.The room was cleaned and items that were improperly storedwere moved.</p> <p>The Manager of Health Center Activities will monitorthe closet and will report in monthly QA meetings any problems or concerns andsupporting documentation will be given to Dir. of Campus Environment andCompliance for 6 months. At the end ofthe 6 months, the QA team may choose to cease the monthly audits, if the auditsreveal 100% compliance</p>	

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K 0000 Bldg. 06	<p>janitorial supplies were also stored within three feet of the transfer switch in the electrical room. Based on interview at the time of observation, the Director of Plant Operations acknowledged working space was not maintained for the emergency transfer switch in the aforementioned electrical room.</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: 12/30/15</p> <p>Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600</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,</p>	K 0000		

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	<p>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 126 at the time of this survey.</p> <p>All areas where residents have customary</p>			

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K 0046 SS=E Bldg. 06	<p>access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed 01/05/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review, observation, and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 3 battery operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a 30 second functional test to be conducted at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration.</p> <p>Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect 10 residents, staff and visitors using the interior walkway between Aspen Commons and Juniper Commons.</p> <p>Findings include:</p>	K 0046	<p>1. In the Loggia corridor, the two battery powered emergency lighting systems were not tested on a monthly and annual basis.</p> <p>1. Turner Construction was contacted and with the assistance of Gaylor Electric, to determine the purpose of the additional lighting since there is already emergency hallway lighting in corridors. It was determined that the battery pack lights were provided in order to attain the 1 ft-candle lighting for the means of egress pathway in the event of a power failure and will remain in place.</p> <p>2. During audits, no residents were found to be harmed.</p> <p>3. A "monthly 30 second test" was added to the already in place monthly sprinkler visual inspection PM work order. The "annual 90 minutes" test was added to the Cedar Commons Emergency Generator Check Sheet to be performed at the same time. (see attached work</p>	01/29/2016

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	<p>Based on record review with the Director of Campus Environment and the Director of Plant Operations from 9:30 a.m. to 12:00 p.m. on 12/30/15, documentation of monthly functional testing and annual testing for battery powered emergency lighting systems located in the interior walkway between Aspen Commons and Juniper Commons was not available for review. Based on observations with the Director of Campus Environment and the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, two battery powered emergency lighting systems were located in the interior walkway between Aspen Commons and Juniper Commons and each light functioned when its respective test button was pushed. Based on interview at the time of record review and of the observations, the Director of Plant Operations acknowledged monthly and annual functional testing documentation for the aforementioned two battery operated emergency lights in the facility within the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p>		<p>order and check sheet) 4. Education of safety committee was completed on 1-13-16a detailing the added duties as part of their inspection check sheet focusing on this infraction. (see attached) 5. Bi-monthly – Safety inspection reports will be given to Dir. of Campus Environment and Compliance. (see attached check sheet) 6. Director of Plant Operations will monitor check sheet and will report in monthly QA meetings any problems or concerns and supporting documentation will be given to Dir. of Campus Environment and Compliance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthly audits, if the audits reveal 100% compliance.</p>	

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K 0050 SS=F Bldg. 06	<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 document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Report: Fire" with the Director of Campus Environment and the Director of Plant Operations during record review from 9:30 a.m. to 12:00 p.m. on 12/30/15, documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) of 2015 was not available for review. Based on interview at the time of record review, the Director of Campus Environment acknowledged</p>	K 0050	<p>A fire drill report was not available for review for the 2ndquarter (April, May, and June 2015) on the 2nd Shift. This resulted in 5 K0050 tags due to the buildingsbeing considered separated- 01, 03, 05, 06, and 07.</p> <p>1.Work orders have been entered in Worxhub (electronicwork order program) that will be generated on a monthly basis to perform firedrill on the 2nd Shift and an electronic response will be generatedonce complete. (copy attached)</p> <p>2.During audits, no residents were found to be harmed.</p> <p>3.On a monthly basis, the Dir. of Plant Operations willcomplete a check sheet making sure he has received the completed Fire Drillreports from nurse stations following a fire drill. (copy attached log)</p> <p>4.Director of Plant</p>	01/29/2016

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K 0064 SS=D Bldg. 06	<p>documentation of a fire drill conducted on the second shift in the aforementioned quarter was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</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 facility failed to maintain portable fire extinguishers in 1 of 2 kitchen cooking areas 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 use 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</p>	K 0064	<p>Operations will report in monthly QA meetings any problems or concerns and supporting documentation will be given to Dir. of Campus Environment and Compliance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthly audits, if the audits reveal 100% compliance.</p> <p>The required Placard was not placed near the K Class Extinguisher in Aspen Kitchen.</p> <p>1. Immediately following the survey, a temporary placard was placed above the fire extinguisher that reads, "in case of fire, the overhead hood extinguishing system MUST be activated first before using a portable fire extinguisher. Additionally, activating the overhead extinguishing system will automatically shut off the fuel source to the cooking appliance. The portable fire extinguisher is a supplemental protection". The temporary sign was replaced with a permanent sign from Koorsen Fire Protection on 1-8-16 (see photo)</p> <p>2. During an audit, no residents were found to be harmed.</p> <p>3. Education of safety committee was completed on</p>	01/29/2016

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K 0144 SS=F Bldg. 06	<p>instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff and visitors in the Aspen Commons kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environment during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, a portable K Class fire extinguisher was located in the Aspen Commons kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Director of Campus Environment acknowledged a placard was not conspicuously placed near the portable K Class fire extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher.</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.</p>		<p>1-13-16a detailing the added duties as part of their inspection check sheet focusing on this infraction. (see attached)</p> <p>4.Safety inspection bi-monthly – inspection reports will be given to Dir. of Campus Environment and Compliance for Quality Assurance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthly audits, if the audits reveal 100% compliance. (see attached check sheet)</p>	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 3 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building. This deficient practice could affect 60 residents, staff and visitors in Aspen Commons and Willow Commons.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environment and the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, the 250 kW emergency generator located outside Willow Commons lacked a remote shut off device. Manufacturer's information affixed to the nameplate of the emergency generator indicated the unit was manufactured 03/15/13. Based on interview at the time of observation, the</p>	K 0144	<p>The 3 Generators (Aspen/Willow; Heatherwood/Juniper; CedarCommons) were found that they lacked a remote shut off device.</p> <p>1. Following the inspection, Turner Construction was notified to assist in getting bids to install a remote shut off device for each generator.</p> <p>2. During an audit, no residents were found to be affected.</p> <p>3. A meeting with Ermco Electric, Turner Construction and Dir. of Plant Operations on Thursday, Jan. 14, 2016 and waiting for estimate to install. (see attached)</p> <p>4. Going forward, when a new generator is installed, the Director of Plant Operations make sure that the installers are made aware that a remote shut off is required and installed according to NFPA 110, Standard for Emergency and Standby Power Systems from the NFPA 110, 1999 edition, 3-5.5.6 per requirements.</p>	01/29/2016

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K 0000 Bldg. 07	<p>Director of Plant Operations stated the emergency generator was installed after 2003 and acknowledged there was no remote shut off device for the aforementioned emergency generator.</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: 12/30/15</p> <p>Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600</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. Buildings 0103, 0105, 0106 and 0107 were surveyed with Chapter 18, New Health Care</p>	K 0000		

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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 126 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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K 0018 SS=E Bldg. 07	<p>Quality Review completed 01/05/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors did not have an impediment to closing and latching. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Heatherwood Commons Activities Room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Campus Environment and the Director of Plant Operations during a tour of the facility from 12:00 p.m. to 3:10 p.m. on 12/30/15, the corridor door to the Heatherwood Commons Activities Room had an affixed kick down door stop which was in use to prop the door in the fully open position. Based on interview at the time of observation, the Director of Campus Environment acknowledged the aforementioned corridor door had an affixed kick down door stop which was</p>	K 0018	<p>The corridor door to the Heatherwood Activity Room was heldopen with a door stop because it would not stay held open on its own.</p> <p>1.The door stop was removed and door adjusted to remainopen yet able to close by pulling closed and latching into the frame. In addition, an audit was made and othersfound were removed. (work order &photo attached)</p> <p>2.During an audit, no residents were found to beaffected.</p> <p>3.Education of safety committee was completed on 1-13-16detailing the added duties as part of their inspection check sheet focusing onthis infraction. (see attached)</p> <p>4.Safety inspection bi-monthly – inspection reports willbe given to Dir. of Campus Environment and Compliance for Quality Assurance for6 months. At the end of the 6 months,the QA team may choose to cease the monthly audits, if the audits reveal 100%compliance. (see attached check sheet)</p>	01/29/2016
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K 0050 SS=F Bldg. 07	<p>in use and provided an impediment to closing and latching into the door frame.</p> <p>3.1-19(b)</p> <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 document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Report: Fire" with the Director of Campus Environment and the Director of Plant</p>	K 0050	<p>A fire drill report was not available for review for the 2ndquarter (April, May, and June 2015) on the 2nd Shift. This resulted in 5 K0050 tags due to the buildingsbeing considered separated- 01, 03, 05, 06, and 07.</p> <p>1.Work orders have been entered in Worxhub (electronicwork order program) that will be generated on a monthly basis to perform firedrill on the 2nd Shift and an electronic response will be generatedonce complete. (copy attached)</p>	01/29/2016

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	<p>Operations during record review from 9:30 a.m. to 12:00 p.m. on 12/30/15, documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) of 2015 was not available for review. Based on interview at the time of record review, the Director of Campus Environment acknowledged documentation of a fire drill conducted on the second shift in the aforementioned quarter was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>2. During audits, no residents were found to be harmed. 3. On a monthly basis, the Dir. of Plant Operations will complete a check sheet making sure he has received the completed Fire Drill reports from nurse stations following a fire drill. (copy attached log) 4. Director of Plant Operations will report in monthly QA meetings any problems or concerns and supporting documentation will be given to Dir. of Campus Environment and Compliance for 6 months. At the end of the 6 months, the QA team may choose to cease the monthly audits, if the audits reveal 100% compliance.</p>		