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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155177 NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE - WEST LAFAYETTE			LE CONSTRUCTION G <u>01</u>	СОМ	te survey pleted 95/2017
		274	1 N SALISBURY ST		
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
State Licensure the Indiana Stat	Survey was conducted by e Department of Health in	K 0000			
Survey Date: 04	4/05/17				
Provider Number AIM Number: At this Life Safe Westminster Vi found not in con Requirements for Medicare/Medic 483.70(a), Life 2012 edition of Protection Asso Safety Code (LS	er: 155177 201271750 ety Code survey, llage-West Lafayette was mpliance with or Participation in caid, 42 CFR Subpart Safety from Fire and the the National Fire ciation (NFPA) 101, Life SC), Chapter 19, Existing				
Pavilion and Te sprinklered buil Type III (211) c has a fire alarm detection in the sleeping rooms	rrace in a one story ding determined to be of construction. The facility system with smoke corridors, resident and spaces open to the				
	PROVIDER OR SUPPLIE NSTER VILLAGE SUMMARY S (EACH DEFICIENT REGULATORY OF A Life Safety CC State Licensure the Indiana Stata accordance with Survey Date: 0 Facility Numbe Provider Numbe Provider Numbe AIM Number: At this Life Saff Westminster Vi found not in con Requirements fa Medicare/Medica 483.70(a), Life 2012 edition of Protection Asso Safety Code (LS Health Care Occ 16.2. The facility com Pavilion and Te sprinklered buil Type III (211) c has a fire alarm detection in the sleeping rooms	155177 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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). Survey Date: 04/05/17 Facility Number: 000093 Provider Number: 155177 AIM Number: 201271750 At this Life Safety Code survey, Westminster Village-West Lafayette was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC	ISTITSTRSTRSTRZ74WEST LAFAYETTESUMMARY STATEMENT OF DEFICIENCIESIDREGULATORY OR LSC IDENTIFYING INFORMATION)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).Survey Date: 04/05/17Facility Number: 000093 Provider Number: 155177 AIM Number: 201271750At this Life Safety Code survey, Westminster Village-West Lafayette was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.The facility consists of the Courtyard, Pavilion and Terrace in a one story sprinklered building determined to be of Type III (211) construction. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the	ISTRE STREET ADDRESS, CITY, STATE, ZIP STREET ADDRESS, CITY, STATE, ZIP STREET VILLAGE - WEST LAFAYETTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BD FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) 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). Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/05/17 Facility Number: 000093 Provider Number: 155177 AIM Number: 201271750 At this Life Safety Code survey, Westminster Village-West Lafayette was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility consists of the Courtyard, Pavilion and Terrace in a one story sprinklered building determined to be of Type III (211) construction. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the	155177 B. WING 04/0 ROVIDER OR SUPPLIER STREET ADDRESS, CTTY, STATE, ZIP CODE 2741 N SALISBURY ST NSTER VILLAGE - WEST LAFAYETTE WEST LAFAYETTE, IN ASUBURY ST WEST LAFAYETTE, IN ASUBURY ST SUMMARY STATEMENT OF DEFICIENCIES ID PROTOBER PLANOF ORBECTION IEACLORECTV, CTUS SOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG IEACLORECTV, CTUS SOULD BE A Life Safety Code Recertification and TAG IEACLORECTV, CTUS SOULD BE IEACLORECTV, CTUS SOULD BE A Life Safety Code Recertification and K 0000 IEACLORECTV, CTUS SOULD BE IEACLORECTV, CTUS SOULD BE Survey Date: 04/05/17 IEACLORECTV, CTUS SOULD BE IEACLORECTV, CTUS SOULD BE Survey Date: 04/05/17 IEACLORECTV, CTUS SOULD BE IEACLORECTV, CTUS SOULD BE Survey Date: 04/05/17 IEACLORECTV, CTUS SOULD BE IEACLORECTV, CTUS SOULD BE Survey Date: 04/05/17 IEACLORECTV, CTUS SOULD BE IEACLORECTV, CTUS SOULD BE Yestmister Village-West Lafayette was found not in compliance with IEACLORECTV, CTUS SOULD BE Reduciand, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC <t< td=""></t<>

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMEN AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155177		A. BUILDING B. WING	CONSTRUCTION C	 X3) DATE SURVEY COMPLETED 04/05/2017
	PROVIDER OR SUPPLIE	R - WEST LAFAYETTE	2741 1	TADDRESS, CITY, STATE, ZIP CODE N SALISBURY ST TLAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	72 and had a ce this survey.	nsus of 68 at the time of			
	customary acce all areas provid sprinklered.	the residents have ss were sprinklered and ing facility services were			
	Quality Review	r completed on 04/11/17 -			
K 0131 SS=F Bldg. 01	Care Facilities Sections of healt other occupancie * They are not in more inpatients. * They are separ care occupancie minimum 2-hour accordance with * The entire build by an approved, sprinkler system 9.7. Hospital outpatier required to be cla Health Care Occo number of patier 18.1.3.3, 19.1.3. 485.623 Based on obser facility failed to	hcies - Sections of Health h care facilities classified as es meet all of the following: tended to serve four or ated from areas of health s by construction having a fire resistance rating in Chapter 8. ling is protected throughout supervised automatic in accordance with Section nt surgical departments are assified as an Ambulatory upancy regardless of the ts served. 3, 42 CFR 482.41, 42 CFR vation and interview, the o provide a two-hour rated 1 of 1 separation walls	K 0131	The plant operations director contacted the contractor on 4/5/17 to request that the contractor repair the separation	04/23/201
	building and th	isted living portion of the e health care portion of his deficient practice could		wall that separated the Pavilion area from the Assisted Living area. The repair was made per	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155177		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 04/05/2017		
	PROVIDER OR SUPPLIE	- WEST LAFAYETTE	2741	TADDRESS, CITY, STATE, ZIP CODE N SALISBURY ST TLAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	(X5) COMPLETIO DATE
	facility. Findings includ Based on obser facility with the Director on 04/ separation wall Pavilion area fr of the facility s inches from the interview at the Plant Operation the aforemention provided the m	vation during a tour of the e Plant Operations 05/17 at 11:47 a.m., the that separated the om Assisted Living area topped approximately six e ceiling above. Based on e time of observation, the as Director acknowledged oned condition and		NFPA 101 guidelines on 4/2 All separation walls were inspected by 4/23/17 to ensu- each met NFPA 101 guidelin All maintenance staff will be inserviced on separation wal guidelines by 5/5/17. Monthly inspections will be completed the plant operations director his designee to review the aforementioned areas. Find of the inspections will be rep to the Quality Assurance Performance Improvement (QAPI) committee and a performance plan will be established based on the findings. The QAPI committee will meet quarterly.	ire ies. l y d by or or ings orted	
K 0226 SS=E Bldg. 01	B=E Horizontal Exits		K 0226	The plant operations director contacted the contractor on 4/5/17 to request that the contractor provide a quote to repair the fire door sets that separate the Pavilion area fr the Assisted Living area. Th repair will be made per NFP/ guidelines by 5/5/17. Addition horizontal exits were inspect 4/7/17 to ensure each met N	om is A 101 onal ed by	05/05/201

PRINTED: 05/17/2017

	T OF HEALTH AND HU R MEDICARE & MEDIO				FORM APPROVED OMB NO. 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155177				
AND PLAN			A. BUILDING B. WING	<u>01</u>	COMPLETED 04/05/2017
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	•
WESTM	INSTER VILLAGE	- WEST LAFAYETTE		LAFAYETTE, IN 47906	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG	states self-closifiest easily and freely with a closing of close and latch This deficient of compartments. Findings includ Based on obsert the facility with Director on 04/4 fire door set ent wing failed to la The door frame hardware. Base of observation, Director acknow the fire door set magnetic lockin	R LSC IDENTIFYING INFORMATION) ng doors shall swing y and shall be equipped levice to cause the door to each time it is opened. ould affect 1 of 4 smoke e: vations during a tour of the Plant Operations 05/17 at 10:17 a.m., the tering the assisted living atch into the door frame. lacked the latching ed on interview at the time the Plant Operations wledged and confirmed t was equipped with only a ng device which would activation of the fire	TAG	DEFICIENCY) 101 guidelines. All maintena staff will be inserviced on fire guidelines by 5/5/17. Monthly inspections will be completed the plant operations director of his designee to review the aforementioned areas. Findir of the inspections will be report to the Quality Assurance Performance Improvement (QAPI) committee and a performance plan will be established based on the findings. The QAPI committee will meet quarterly.	by or ngs orted
0331 SS=E 3ldg. 01	exposed interior				

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Event ID: V8KU21

Facility ID: 000093

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 155177		(X2) MULTIPLE C A. BUILDING B. WING	<u>01</u>	(X3) DATE SURVEY COMPLETED 04/05/2017
	PROVIDER OR SUPPLIE	R WEST LAFAYETTE	2741 N	ADDRESS, CITY, STATE, ZIP CODE I SALISBURY ST LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIE)	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETIO DATE
TAG	columns, and hav Class A or Class interior finish for a prescribed in 10.2 10.2, 19.3.3.1, 19 Indicate flame sp Based on observ facility failed to an interior finish Data Rooms hav Class A or Class 19.3.3.1. LSC 1 products require accordance with Test Method for Characteristics of ANSI/UL 723, 5 Surface Burning Building Materi the following cl their flame spre development. (a) Class A Inte Finish. Flame sp development 0-	a.3.3.2 read rating(s). vation and interview, the ensure materials used as n on the ceiling in 3 of 3 d a flame spread rating of s B in accordance with 01 10.2.3.4 states ed to be tested in a ASTM E 84, Standard c Surface Burning of Building Materials or Standard for Test for g Characteristics of als shall be grouped in asses in accordance with	TAG K 0331	The plant operations director reviewed the facility documentation and determine that the interior walls and ceil finishings do meet NFPA 101 guidelines. The documentation was located on 4/7/17 after th LSC inspector exited the facil Documentation will be provide with this plan of correction. T guidelines were followed duri the remodel of the facility in 2012.	on he ing he ihe
	flame spread test the smoke test s thereof, when so continue to prop	at scale and 450 or less on cale. Any element to tested, shall not pagate fire.			
	Finish. Flame sj development 0-	rior Wall and Ceiling pread 26-75; smoke 450. Includes any ed at more than 25 but			

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

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			JLTIPLE CO JILDING	NSTRUCTION 01	· · ·	ATE SURVEY MPLETED
	of conduction	155177	B. W		01	- 1	/05/2017
	PROVIDER OR SUPPLIE			2741 N	DDRESS, CITY, STATE, ZIP CO SALISBURY ST	DDE	
	-	WEST LAFAYETTE			AFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
	 scale and 450 or scale. (c) Class C Inter Finish. Flame sp development 0-4 material classifier not more than 20 test scale and 45 test scale. This caffect up to 10 rein the main entry Findings include Based on observe Operations Direca.m., there was vapproximately 4 floor on the wall in the dining are 	e: ation with the Plant ctor on 04/05/17 at 10:17					
	rating of the afor paneling availab be provided. This the Plant Operat of observation.	rementioned wood le for review, none could is was acknowledged by ions Director at the time					
(0341 SS=E	3.1-19(b) NFPA 101 Fire Alarm System	n - Installation					

DDINTED. 05/17/2017

	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROV OMB NO. 0938-	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	01	COMPLETED	
		155177			04/05/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
WESTM	INSTER VILLAGE -	WEST LAFAYETTE		I SALISBURY ST LAFAYETTE, IN 47906		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5))
PREFIX	[×]	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
Bldg. 01	and components in accordance wit Electric Code, an Alarm Code to pro- fire in any part of continuously occu at each fire alarm occupancy, detect notification applia extenders, and su transmitting equip wiring or other tra- monitored for inter 18.3.4.1, 19.3.4.1 Based on observe facility failed to systems was ins 19.3.4.1. NFPA spaces served by detectors shall m flow prevents op A.17.7.4.1 states located in a dire	m is installed with systems approved for the purpose h NFPA 70, National d NFPA 72, National Fire ovide effective warning of the building. In areas not upied, detection is installed control unit. In new tion is also installed at nce circuit power upervising station ment. Fire alarm system nsmission paths are grity.	K 0341	The health facility administrate created a work order on 4/23/ to request that the maintenan technician relocate the smoke detector in the social services office per NFPA 101 guideline This relocation will be made p NFPA 101 guidelines by 5/5/1 All smoke detector heads wer inspected by 4/7/17 to ensure they were at least 36 inches fi direct airflow. All maintenance	117 ce e e e e s s e s	2017

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affect staff and up to 18 residents in the

Based on observation with the Plant

a.m., the Social Services office had a

Operations Director on 04/05/17 at 11:40

smoke detector approximately 24 inches

from an air duct. Based on interview at

the time of the observation, the Plant

smoke compartment.

Findings include:

Event ID:

V8KU21

Facility ID: 000093

staff will be inserviced on smoke

detector placement guidelines by

5/5/17. Monthly inspections will be completed by the plant operations director or his

aforementioned areas. Findings

of the inspections will be reported

designee to review the

to the Quality Assurance Performance Improvement

(QAPI) committee and a

performance plan will be

established based on the findings. The QAPI committee

If continuation sheet

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	R MEDICARE & MEDIC		-		OMB NO. 0938-0391
	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	· · · · · · · · · · · · · · · · · · ·	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	01	COMPLETED
		155177	B. WING		04/05/2017
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				SALISBURY ST	
WESTMI	NSTER VILLAGE -	- WEST LAFAYETTE	WEST	LAFAYETTE, IN 47906	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	-	ector acknowledged the		will meet quarterly.	
	aforementioned	condition.			
	3.1-19(b)				
14 00 40					
K 0346 SS=F	NFPA 101 Fire Alarm System	m - Out of Service			
Bldg. 01	Fire Alarm - Out of				
Blag. 01		ire alarm system is out of			
		than 4 hours in a 24-hour			
		rity having jurisdiction shall			
		he building shall be			
		approved fire watch shall Il parties left unprotected by			
		il the fire alarm system has			
	been returned to	-			
	9.6.1.6				
	Based on record	l review and interview,	K 0346	The fire watch documentation	05/05/2017
	the facility faile	d to provide a complete 1		was amended by the security team leader on 4/7/17 per NFP	٨
	of 1 written poli	icy for the protection of		101 guidelines to include verbia	
	residents indica	ting procedures to be		stating a trained person would	
	followed in the	event the fire alarm		assigned to the fire watch and	
	system has to be	e placed out of service for		that person would have no othe	
	four hours or m	ore in a twenty four hour		tasks or duties. All security staf will be inserviced on this	t l
		lance with LSC, Section		documentation by 5/5/17. Fire	
	-	ficient practice affects all		watch documentation will be	
	occupants.			reviewed by the security team	
	occupants.			leader or his designee upon the	e
	Findings includ	٥.		completion of each fire watch	
	r mangs merua	C.		episode. Findings of the review will be reported to the Quality	v
	Decod on monor	I ravian with the		Assurance Performance	
		l review with the $\frac{1}{2}$		Improvement (QAPI) committee	e
		anager on $02/23/17$ at		and a performance plan will be	
		facility provided fire		established based on the	
		tation but it was		findings. The QAPI committee	
	-	e plan failed to include		will meet quarterly.	
	I that a trained ne	erson had to be assigned		1	

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STATEME AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155177		A. BUILDING B. WING	CONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 04/05/2017
	PROVIDER OR SUPPLI	ER - WEST LAFAYETTE	2741	T ADDRESS, CITY, STATE, ZIP CODE N SALISBURY ST T LAFAYETTE, IN 47906	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	other assigned interview durin	ch, and that they have no tasks or duties. Based on ong the record review, the ns Director acknowledged oned condition.			
< 0353 SS=F Bldg. 01	Sprinkler Systen Automatic sprink are inspected, te accordance with Inspection, Testi Water-based Fir Records of syste inspection and te secure location a a) Date sprinkle b) Who provide c) Water syster Provide in REM/ coverage for any automatic sprink	n supply source ARKS information on non-required or partial ler system.			
9 1 2 2 2 1 1 1	 9.7.5, 9.7.7, 9.7. 1) Based on real and interview; document sprin accordance with Standard for the Maintenance on Protection Systems 		K 0353	The plant operations director created a check system to inspect dry pipe sprinkler systems, fire department connections and valves on 4, per NFPA 101 guidelines. Th aforementioned areas have b inspected weekly beginning of 4/7/17. Additionally, the plan	/7/17 ne been bn

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155177	CATION NUMBER: A. BUILDING <u>01</u>		(X3) DATE SURVEY COMPLETED 04/05/2017	
	PROVIDER OR SUPPLIE	R - WEST LAFAYETTE	2741 N	ADDRESS, CITY, STATE, ZIP C I SALISBURY ST LAFAYETTE, IN 47906	ODE	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETI DATE
	weekly to ensur condition and th pressure is bein 5.1.2 states valv connections sha and maintained Chapter 13. Sec valves shall be 4.3.1 states reco inspections, tes system and its of made available jurisdiction upo	hs shall be inspected that they are in good hat normal water supply g maintained. Section res and fire department and fire department ll be inspected, tested, in accordance with the tion 13.3.2.1 states all inspected weekly. Section bords shall be made for all its, and maintenance of the components and shall be to the authority having n request. This deficient ffect all clients and staff		operations director con protection contractor to an automatic sprinkler system internal inspect inspection will occur by All maintenance staff w inserviced on the dry p sprinkler systems, fire of connections and valve by 5/5/17. Monthly insj will be completed by th operations director or h designee to review the aforementioned areas. of the inspections will b to the Quality Assurant Performance Improven (QAPI) committee and performance plan will b established based on th findings. The QAPI con will meet quarterly.	o schedule piping ion. The o 5/5/17. vill be ipe department guidelines pections e plant his Findings be reported ce nent a be	
	Inc. "Report of documentation 07/05/2016, and no documented inspections note inspection docu sprinkler system not available fo interview at the the Plant Opera acknowledged gauge inspection weekly control	v of Ace Fire Protection Inspection / Test" dated 04/04/17, 12/27/16, d 04/05/2016, there were weekly sprinkler gauge ed. In addition, weekly mentation for all n control valves was also r review. Based on time of record review, tions Director weekly sprinkler system n documentation and valve inspection for the aforementioned			QAPI committee	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155177	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		CO 04	ate survey Mpleted /05/2017	
	PROVIDER OR SUPPLIEF	WEST LAFAYETTE		2741 N	DDRESS, CITY, STATE, ZIP (SALISBURY ST AFAYETTE, IN 47906	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	periods, was not	available for review.					
	3.1-19(b)						
	the facility failed automatic sprink examined for int conditions exist obstructed pipin 25, 2011 Edition Inspection, Testi Water-Based Fin section 14.2.2. T	ord review and interview, d to ensure 1 of 1 there piping systems was ernal obstructions where that could cause g as required by NFPA a, the Standards for the ing and Maintenance of re Protection Systems, This deficient practice nts, staff and visitors.					
	Findings include	:					
	Operations Direct a.m., the most cu inspection availa September 12th interview with the Director at the ti stated that a more	review with the Plant etor on 04/05/17 at 10:47 urrent internal pipe able for review was dated of 2008. Based on an he Plant Operations me of record review, he re current internal pipe not available for review.					
	3.1-19(b)						

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

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155177	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		COMPLETED 04/05/2017		
	PROVIDER OR SUPPLIE	R - WEST LAFAYETTE		2741 N	ADDRESS, CITY, STATE, ZIP CODE SALISBURY ST LAFAYETTE, IN 47906		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0711 SS=E Bldg. 01	all patients and fevent of an emer Employees are p kept informed with plan, and a copy available with tel security. The pla response require and provides for components per 18.7.1.1 through 18.7.2.2, 18.7.2.3 19.7.2.1.2, 19.7.3 Based on record the facility faild written emergen incorporated all 101, Section 19 1. Use of alarm 2. Transmission department 4. Response to 5. Isolation of 6. Evacuation of 7. Evacuation of 8. Preparation evacuation. 9. Extinguishm This deficient p	Relocation Plan o plan for the protection of or their evacuation in the gency. eriodically instructed and the their duties under the of the plan is readily ephone operator or with n addresses the basic d of staff per 18/19.7.2.1.2 all of the fire safety plan 18/19.2.2. 18.7.1.3, 18.7.2.1.2, 3, 19.7.1.1 through 19.7.1.3, 2.2, 19.7.2.3 d review and interview, ed to provide 1 of 1 ney fire safety plan that d items listed in NFPA .7.2.2. ns. n of alarms to fire alarms. fire. of immediate area. of smoke compartment. of floors and building for	K 0'	711	The emergency fire safety plat will be amended by the securit team leader by 4/28/17 per NF 101 guidelines to include instructions for the evacuation an immediate area and/or the evacuation of a smoke compartment. Additionally, the emergency fire safety plan will reviewed by the security team leader by 4/28/17. All security staff will be inserviced on this emergency fire safety plan by 5/5/17. The emergency fire safety plan will be reviewed by security team leader or his designee upon the completion each monthly fire drill. Finding of the review will be reported t the Quality Assurance Performance Improvement (QAPI) committee and a performance plan will be established based on the findings. The QAPI committee	ey PA of be y the of gs o	05/05/201

ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				0	MB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	JILDING	<u>01</u>	COM	PLETED
		155177	B. WI	NG		04/0	5/2017
				STREET	ADDRESS, CITY, STATE, ZIP (CODE	
NAME OF	PROVIDER OR SUPPLIEI	R		2741 N	SALISBURY ST		
WESTM	INSTER VILLAGE -	WEST LAFAYETTE		WEST	LAFAYETTE, IN 47906		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COI	PRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETIC
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Findings include	e:			will meet quarterly.		
		6.4 6 11.7					
	Based on review						
		al" documentation with					
	-	tions Director during					
		t 11:00 a.m. on 04/05/17,					
		safety plan did not					
		ion of the immediate area					
		f a smoke compartment.					
		iew at the time of record					
		t Operations Director					
	-	he aforementioned					
	missing item in	the facilities written fire					
	safety plan.						
	3.1-19(b)						
0918	NFPA 101						
SS=F		s - Essential Electric Syste					
3ldg. 01	System Maintena	s - Essential Electric					
		other alternate power					
	source and assoc	iated equipment is capable					
		ce within 10 seconds. If the					
		on is not met during the					
		ocess shall be provided to this capability for the life					
		branches. Maintenance					
		generator and transfer					
		ormed in accordance with					
	NFPA 110.	a increated weakly					
		e inspected weekly, oad 30 minutes 12 times a					
		intervals, and exercised					
		onths for 4 continuous					
		test under load conditions					
	I include a complet	e simulated cold start and			1		1

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OMB NO. 0938-0391

STATEMENT AND PLAN O	F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155177	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 04/05/2017	
	ROVIDER OR SUPPLIEF	WEST LAFAYETTE	2741 N	ADDRESS, CITY, STATE, ZIP CODE I SALISBURY ST LAFAYETTE, IN 47906		
	(EACH DEFICIEN REGULATORY OR automatic or man	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ual transfer of all EES inducted by competent	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
	personnel. Mainter stored energy pow are in accordance feeder circuit breat annually, and a pre exercising the cor according to many Written records of are maintained ar electrical panels at readily identifiable of damage of the is a design conside installations. 6.4.4, 6.5.4, 6.6.4 NFPA 111, 700.10 Based on record the facility failed failed to ensure generators was at down period after document the trat alternate power at supplying service Chapter 6.4.4.1. requires monthly serving the ement to be in accordant Standard for Em Powers Systems 6.2.10 Time Del requires that a m minutes shall be running of the E	Anance and testing of ver sources (Type 3 EES) with NFPA 111. Main and akers are inspected rogram for periodically nponents is established ufacturer requirements. The maintenance and testing ad readily available. EES and circuits are marked and a. Minimizing the possibility emergency power source deration for new (NFPA 99), NFPA 110, 0 (NFPA 70) review and interview, d to ensure he facility 1 of 1 emergency illowed a 5 minute cool	K 0918	The plant operations director created a check system on 4/7/7 to log the cool down period on the generator after it had completed its monthly load test per NFPA 101 guidelines. The generator was inspected on 4/7/17 to ensure that it did properly cool down after it completed the monthly load test per NFPA guidelines. All maintenance staff will be inserviced on this generator cool down guidelines by 5/5/17. Monthly inspections will be completed by the plant operations director or his designee to review the aforementioned area. Findings the inspections will be reported the Quality Assurance Performance Improvement (QAPI) committee and a performance plan will be established based on the	ne f of	

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	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CO 2741 N SALISBURY ST WEST LAFAYETTE, IN 47906	DDE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)provides additional engine cool down.This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.Findings include:Based on record review with the Plant Operations Director on 04/05/17 at 10:17 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Plant Operations Director acknowledged the aforementioned condition.3.1-19(b)	ID PREFIX TAG TAG Findings. The QAPI con will meet quarterly.	DULD BE COMPLETION DATE

V8KU21 Facility ID: 000093