PRINTED: 09/05/2024

	T OF HEALTH AND HUI						RM APPROVED
	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	III.TIPI E C	ONSTRUCTION	(X3) DATE	B NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER 155167	A. BUILDING B. WING		<u></u>	COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
E 0000							
Bldg	conducted by the In accordance with 42 Survey Date: 08/14 Facility Number: 0 Provider Number: 100 At this Emergency Westminster Villag compliance with En Requirements for N Participating Provid 483.73. The facility has 148 the survey, the censility Review con Quality Review con	000084 155167 284600 Preparedness survey, e North was found not in mergency Preparedness dedicare and Medicaid ders and Suppliers, 42 CFR 8 certified beds. At the time of sus was 111. mpleted on 08/19/24 42 CFR, Subpart 483.73 is NOT	E 00	000	The submission of this plan of correction shall not be construed as an admission that Westmin Village North Health Center provides anything other than a high quality of care to its residents. Westminster Village North considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the service provided in long-term care facilities. We believe that any feedback provided to us shoul taken very seriously, and we accommitted to using our resour to make any adjustments necessary to achieve better outcomes for residents. As required, the facility submit the following plan of correction Westminster Village North is requesting a desk review of the plans of corrections submitted	ed ster er es d be are ces s n:	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484 485.625(d)(2), 48	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.542(d)(2), 5.68(d)(2), 485.727(d)(2), 6.360(d)(2), 491.12(d)(2),					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

416.54(d)(2), 418.113(d)(2), 441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), 483.475(d)(2), 484.102(d)(2), 485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)

EP Testing Requirements

TITLE (X6) DATE

Kevin Ward **Executive Director** 08/30/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9H7H21 Facility ID: 000084 Page 1 of 36 If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION G	ſ ´	E SURVEY PLETED
		155167	B. WING		08/14	4/2024
	PROVIDER OR SUPPLIEF		110	EET ADDRESS, CITY, STATI 50 PRESBYTERIAN D IANAPOLIS, IN 46236	DR	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLA	N OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICII		DATE
	(2), §485.920(d)(2 (2).	2), §491.12(d)(2), §494.62(d)				
	*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:					
	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:					
	(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group					
	discussion using a clinically-relevant set of problem sta	emergency scenario, and a				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084

If continuation sheet Page 2 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155167		l í	JILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 08/14/2024			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		pared questions designed						
	to challenge an e							
	(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise							
	the tracility's eme	ergency plan, as needed.						
	*(Ear Haspiess at	419 113/d\·1						
	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in							
	the patient's home. The hospice must							
conduct exercises to test the emergency								
	plan at least annually. The hospice must do							
	the following:							
	(i) Participate in a full-scale exercise that is							
	community based every 2 years; or							
		nunity based exercise is not						
	accessible, condu	uct an individual facility						
	based functional	exercise every 2 years; or						
	(B) If the hospice	experiences a natural or						
	man-made emerg	gency that requires activation						
	of the emergency	plan, the hospital is						
		aging in its next required full						
	_	based exercise or individual						
		ctional exercise following the						
	onset of the emer	-						
	` '	dditional exercise every 2						
		ne year the full-scale or						
		e under paragraph (d)(2)(i)						
		conducted, that may limited to the following:						
		-scale exercise that is						
		or a facility based						
	functional exercis	•						
	(B) A mock disas							
	, ,	ercise or workshop that is						
	, ,	and includes a group						
	discussion using	- ·						
		emergency scenario, and a						
set of problem statements, directed messages, or prepared questions designed								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084

If continuation sheet Page 3 of 36

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155167	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/14/2024	
	ROVIDER OR SUPPLIER			11050 F	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR APOLIS, IN 46236			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	to challenge an er	mergency plan.						
	(3) Testing for hose care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a community-(A) When a community-based functional exercise emergency exempt from engated full-scale community functional exercise emergency event. (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercise (B) A mock disast (C) A tabletop exercise facilitator that inclusing a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the himaintain documer exercises, and emergency's emergency is emergency to the hospice's emergency.	spices that provide inpatient hospice must conduct he emergency plan twice spice must do the following: an annual full-scale exercise -based; or nunity-based exercise is not ct an annual individual stional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required aity based or facility-based the following the onset of the diditional annual exercise but is not limited to the scale exercise that is or a facility based the; or ter drill; or ercise or workshop led by a sudes a group discussion clinically-relevant rio, and a set of problem the ded messages, or prepared the do challenge an ospice's response to and antation of all drills, tabletop mergency events and revise tergency plan, as needed.						
	*[For PRFTs at §4 §482.15(d), CAHs	41.184(d), Hospitals at at §485.625(d):]						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 4 of 36

PRINTED: 09/05/2024

	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES								
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	ONSTRUCTION	(X3) DATE	IB NO. 0938-039 SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILE	ING		COMPL			
		155167	B. WING	_		08/14	/2024		
NAME OF F	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD				
					PRESBYTERIAN DR				
WESTMI	NSTER VILLAGE N	NORTH		NDIAN.	APOLIS, IN 46236				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE		
	` '	PRTF, Hospital, CAH] must							
		s to test the emergency							
	l · · · · · ·	ar. The [PRTF, Hospital,							
	CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not								
	` ′	ict an annual individual,							
	facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency								
		is exempt from engaging in							
		ull-scale community based							
		ty-based functional exercise							
	_	et of the emergency event.							
	1 ' '	an [additional] annual							
		at may include, but is not							
	limited to the follo	wing. scale exercise that is							
	community-based								
		ctional exercise; or							
	· -	ock disaster drill; or							
	` '	exercise or workshop that							
	. , ,	or and includes a group							
	discussion, using	a narrated,							
	clinically-relevant	emergency scenario, and a							
	set of problem sta								
		pared questions designed							
	to challenge an er								
	. , ,	he [facility's] response to							
		umentation of all drills,							
		s, and emergency events cility's] emergency plan, as							
	needed.	omy of emergency plan, as							
	nocucu.								
	*[For PACE at §46	60.84(d):]							

FORM CMS-2567(02-99) Previous Versions Obsolete

(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 5 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155167				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIEI		11	050 P	DDRESS, CITY, STATE, ZIP COD RESBYTERIAN DR APOLIS, IN 46236			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG	REGULATORY OF organization must	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE	
	_	an annual full-scale exercise						
	that is community							
	' '	nunity-based exercise is not						
		ıct an annual individual,						
		ctional exercise; or						
	(B) If the PACE endorman-made emo							
	activation of the e							
	is exempt from er							
	full-scale commur							
		ctional exercise following the						
	onset of the emer	gency event.						
	(ii) Conduct an additional exercise every							
	2 years opposite the year the full-scale or							
		e under paragraph (d)(2)(i)						
		conducted that may include,						
	but is not limited t	_						
	' '	-scale exercise that is I or individual, a facility						
	based functional	-						
	(B) A mock disas							
	' '	ercise or workshop that is						
		and includes a group						
	discussion, using	a narrated,						
	-	emergency scenario, and a						
	•	atements, directed						
		pared questions designed						
	to challenge an e	mergency plan. PACE's response to and						
	. ,	ntation of all drills, tabletop						
		nergency events and revise						
		gency plan, as needed.						
	*[For LTC Facilities at §483.73(d):]							
	, ,	ity] must conduct exercises ency plan at least twice per						
	_	announced staff drills using						
	1	ocedures. The [LTC facility,						
	ICF/IID] must do t							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084

If continuation sheet Page 6 of 36

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155167	B. WING		08/14/2024
NAME OF F	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD	
				PRESBYTERIAN DR	
WESTMI	NSTER VILLAGE N	NORTH	INDIA	NAPOLIS, IN 46236	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE	RIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		an annual full-scale exercise			
	that is community				
	' '	nunity-based exercise is not			
	facility-based fund	ct an annual individual,			
		ility] facility experiences an			
	actual natural or man-made emergency that				
	requires activation of the emergency plan, the				
	LTC facility is exempt from engaging its next				
	required a full-scale community-based or				
	individual, facility-based functional exercise				
	following the onset of the emergency event.				
	(ii) Conduct an additional annual exercise				
	that may include, but is not limited to the				
	following:				
	_	scale exercise that is			
	' '	or an individual, facility			
	based functional e	_			
	(B) A mock disas	ter drill; or			
	(C) A tabletop ex	ercise or workshop that is			
	led by a facilitator	includes a group			
	discussion, using	a narrated,			
	clinically-relevant	emergency scenario, and a			
	set of problem sta	tements, directed			
	messages, or pre	pared questions designed			
	to challenge an er	- · · ·			
	_ ` ' -	LTC facility] facility's			
	1	naintain documentation of			
	·	exercises, and emergency			
		e the [LTC facility] facility's			
	emergency plan, a	as needed.			
	*[For ICF/IIDs at §	§483.475(d)]:			
	(2) Testing. The ICF/IID must conduct				
	exercises to test the emergency plan at least twice per year. The ICF/IID must do the				
	following:				
	_	n annual full-scale exercise			
	that is community				
	_	nunity-based exercise is not			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $9H7H21 \qquad {\tt Facility\ ID:} \quad 000084$

If continuation sheet Page 7 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167			A. BUILDING B. WING	JNSTRUCTION	COMP	LETED 1/2024
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COL)	
WESTMI	NSTER VILLAGE N	IORTH		PRESBYTERIAN DR IAPOLIS, IN 46236		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	CTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION ct an annual individual,	TAG	BENEEN		DATE
		tional exercise; or.				
	•	experiences an actual				
	natural or man-made emergency that requires					
		mergency plan, the ICF/IID				
		gaging in its next required				
	•	ity-based or individual,				
		tional exercise following the				
	onset of the emerg	gency event.				
	(ii) Conduct an add	ditional annual exercise				
	that may include, but is not limited to the					
	following:					
	(A) A second full-scale exercise that is					
	community-based or an individual,					
	facility-based func					
	(B) A mock disaste					
		rcise or workshop that is				
	•	and includes a group				
	discussion, using					
	-	emergency scenario, and a				
	set of problem stat					
		pared questions designed				
	to challenge an en	F/IID's response to and				
	, ,	ntation of all drills, tabletop				
		ergency events, and revise				
	· ·	gency plan, as needed.				
		JJ plan, at 1100000				
	*[For HHAs at §48	34.102]				
		e HHA must conduct				
	exercises to test th	ne emergency plan at				
		e HHA must do the				
	following:					
		full-scale exercise that is				
	community-based;					
	` '	ommunity-based exercise				
	is not accessible,					
		based functional exercise				
	every 2 years; or.					
	(B) If the HHA experiences an actual					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 8 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		A. BUILDING B. WING	COMPLETED 08/14/2024		
	F PROVIDER OR SUPPLIEF MINSTER VILLAGE N		11050	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR IAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	(X5) COMPLETION DATE
	natural or man-ma activation of the e exempt from enga full-scale commun facility based functions onset of the emer. (ii) Conduct an ad years, opposite the functional exercise of this section is conclude, but is not (A) A second community-based facility-based function (B) A mock decommunity-based facility-based function (C) A tableton is led by a facilitate discussion, using clinically-relevant set of problem state messages, or present to challenge an erecommunity function (iii) Analyze the Hemaintain documer exercises, and emercises, and emercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statement prepared question emergency plan.	ade emergency that requires mergency plan, the HHA is aging in its next required aity-based or individual, ational exercise following the gency event. ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, ational exercise; or is aster drill; or or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and antation of all drills, tabletop mergency events, and revise ency plan, as needed. 36.360] 4 OPO must conduct the emergency plan. The			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 9 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/14/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	OPO is exempt from required testing exports of the emergency (ii) Analyze the Office maintain documer exercises, and emithe [RNHCl's and needed. *[RNCHIS at §403 (d)(2) Testing. The exercises to test to the standard of the company of the emergency procedures. The exercises to test to the standard of the emergency procedure of the emergency pr	PO's response to and ntation of all tabletop hergency events, and revise OPO's] emergency plan, as a 3.748]: Pe RNHCI must conduct he emergency plan. The her following: Per-based, tabletop exercise a led by a facilitator, using a relevant emergency plan. The hergency plan and response to and hergency plan. The hergency plan and hergency plan and hergency events, and revise regency plan, as needed. Priew and interview, the facility hercises to test the emergency plan hergency plan as needed. Priew and interview, the facility hercises to test the emergency plan hergency	E 0039	E039 – Emergency Preparedness Deficiency: The facility failed to provide documentation of a full-scale, community-based conditionally, facility did not document any actual natural or man-made emergency that required active of the emergency plan within same period. Corrective Action: The facility will immediately	or ional nt the ation		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084

If continuation sheet Page 10 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155167	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/14/2024	
NAME OF I	PROVIDER OR SUPPLIEI			STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	FROVIDER OR SUFFEIEI				PRESBYTERIAN DR		
WESTMI	INSTER VILLAGE N	NORTH		INDIAN	IAPOLIS, IN 46236		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	or individual, facility-based			coordinate with local emerger	•	
		l exercise for 1 year following			management agencies to plan	n and	
	the onset of the act				participate in a full-scale,		
	1 1	itional exercise that may			community-based exercise. A		
		imited to the following:			request for a full-scale drill ha		
	a. A second full-sca				been sent to the Lawrence Fir	е	
	1	or an individual, facility-based			Department.		
	functional exercise				Documentation of any future		
	b. A mock disaster				exercises, including objectives	5,	
	•	ise or workshop that is led by a			participation, and after-action		
		ides a group discussion, using			reports, will be maintained and	a	
	· ·	y-relevant emergency scenario, n statements, directed			reviewed by the Emergency		
	•				Preparedness Committee.		
	messages, or prepared questions designed to challenge an emergency plan.				Ongoing Monitoring:	h =	
	challenge an emergency plan. (iii) Analyze the LTC facility's response to and				Quarterly Emergency Drills: T	ne	
		ation of all drills, tabletop			facility will conduct quarterly		
		rgency events, and revise the			emergency drills, alternating between different scenarios (
		gency plan, as needed in			fire, severe weather, power or	•	
	-	CFR 483.73(d)(2). This			to ensure comprehensive	ilage)	
		ould affect all occupants.			preparedness. These drills wi	l ha	
	deficient practice es	oute arreet air occupants.			documented and reviewed by		
	Findings include:				Emergency Preparedness	uic	
	i manigs merade.				Committee.		
	Based on review of	"Emergency Operations Plan"			Annual Full-Scale Exercise: T	he	
		ed 08/02/24 with the Associate			facility will ensure participation		
		, the Director of Campus			at least one, community-base		
		ne Health Center Technician			facility-based functional exerc		
		w from 9:30 a.m. to 1:00 p.m. on			annually. Documentation of th		
	_	tation for a full-scale exercise			exercises will be maintained a		
	·	based or an individual,			available for review during fut		
		ional exercise within the most			surveys.		
		iod was not available for			Audit and Review: The Emerg	jency	
		y also did not document any			Preparedness Committee will		
	actual natural or ma	an-made emergency that			conduct a bi-annual audit of a		
		of the emergency plan within			emergency preparedness		
	the most recent two	year period. No other			documentation to ensure that	all	
		esting the facility's emergency			exercises, drills, and any actu		
		vailable for review at the time			emergencies are properly		
		ed on interview at the time of			documented. Any deficiencies	;	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155167	B. W	NG		08/14/	/2024
				_			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					PRESBYTERIAN DR		
WESTMI	NSTER VILLAGE N	IORTH		INDIAN	APOLIS, IN 46236		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	record review, the A	Associate Executive Director			identified will be corrected		
	stated the employee	who maintains that			immediately, and staff will rece	eive	
	documentation for t	he facility was not currently			additional training as needed.		
	available and agree	d emergency preparedness			Follow-Up: The results of the a	audit	
	testing documentation was not available for				will be presented to the facility	's	
	review at the time of the survey.				leadership team, and any		
					recommendations for improve	ment	
	These findings were	e reviewed with the Executive			will be implemented within 30		
	Director, the Associ	iate Executive Director, the			days.		
	Director of Campus	Environment and the Health			Plan Completion Date: The fac	cility	
	Center Technician of	during the exit conference.			anticipates that all corrective		
					actions will be completed by		
					October 1, 2024. The Emerge	ncy	
					Preparedness Committee will		
					oversee the implementation of	this	
					Plan of Correction and ensure	that	
					all future exercises and		
					emergencies are documented	as	
					required.		
K 0000							
Bldg. 01							
-	A Life Safety Code	Recertification and State	K 0	000	The submission of this plan of		
	Licensure Survey w	vas conducted by the Indiana			correction shall not be constru		
	Department of Heal	th in accordance with 42 CFR			as an admission that Westmin	ster	
	483.90(a).				Village North Health Center		
					provides anything other than a	1	
	Survey Date: 08/14	1/24			high quality of care to its		
					residents. Westminster Village	•	
	Facility Number: 0	00084			North considers itself to be a		
	Provider Number:	155167			partner with the Indiana State		
	AIM Number: 100284600				Department of Health and othe	er	
					entities in an ongoing effort to		
	At this Life Safety Code survey, Westminster				continually improve the service	es	
	Village North was found not in compliance with				provided in long-term care		
	Requirements for Participation in				facilities. We believe that any		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),				feedback provided to us shoul	d be	
	Life Safety from Fi	re and the 2012 Edition of the			taken very seriously, and we a		
	-	ction Association (NFPA) 101,			committed to using our resour		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $9H7H21 \qquad {\tt Facility\ ID:} \quad 000084$

If continuation sheet Page 12 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155167		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIEF		11050	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR NAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE OF THE APPROPRIATE	ION (X5) D BE COMPLETION DPRIATE DATE
	Chapter 19, Existing 410 IAC 16.2. This one story facilic consists of Building 0107. Building 010 Commons, Heather Commons and Junical and was determined construction and fur Administration Wir was built in 2005 at Type V (111) const Cedar Commons, in each built in 2013 at Type V (111) const The new Dining Roaddition to Memory 0107, was built in 2017, was built in 2017, was built in 2017, was built in 2018 at feeting in the corridor. All reprovided with smoking alarm system. The alarm system. The alarm system. The alarm system were sprinklered an services were sprinklered an services were sprinklered corridors.	ity with a partial basement as 0101, 0103, 0105, 0106 and only, which consists of Willow wood Commons, Aspen over Commons was built in 1974 at to be of Type V (111). The injury sprinklered. The ag, identified as Building 0103, and was determined to be of ruction and fully sprinklered. Identified as Building 0105 and dentified as Building 0106 were and were determined to be of ruction and fully sprinklered. One, kitchen and walkway are Care, identified as Building 014 and was determined to be anstruction and fully sprinklered. The alarm system with smoke are alarm system with smoke are detectors hard wired to the of the facility has a capacity of the facility has a capacity of the office of the		to make any adjustments necessary to achieve bette outcomes for residents. As required, the facility su the following plan of corre Westminster Village North requesting a desk review plans of corrections subm	er bmits ction: is of the
K 0131 SS=E Bldg. 01	Care Facilities	cies cies - Sections of Health care facilities classified as			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 13 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 01 COMPLETED			
		155167	B. WI	NG		08/14	/2024
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	INSTER VILLAGE N				PRESBYTERIAN DR IAPOLIS, IN 46236		
	1				I		l aus
(X4) ID		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		s meet all of the following:		IAG			DATE
	Other occupations.	Theet an of the following.					
	o They are not in	tended to serve four or					
	I	r purposes of housing,					
	treatment, or cust						
	o They are sepa	rated from areas of health					
	care occupancies	-					
		aving a minimum two hour					
	fire resistance rati	_					
	accordance wi	•					
	o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance						
	with Section 9.7.						
	With Occion 5.7.						
	Hospital outpatier	t surgical departments are					
		ssified as an Ambulatory					
		pancy regardless of the					
	number of patient						
		482.41, 42 CFR 485.623		101			10/01/2024
		on and interview, the facility	K 0	131	K131 – Multiple Occupancies		10/01/2024
		ne 2-hour fire rated separation nursing unit and the attached			Deficiency: This deficiency wa cited due to the latching	ıs	
		area in accordance with			mechanisms on the corridor d	oor	
		This deficient practice could			that serves as the entrance to		
		ents, staff and visitors if			Independent Living from Skille		
		facility from Heatherwood			Nursing, being "dogged down"		
	Commons.				therefore unable to latch onto		
					door frame.		
	Findings include:				Corrective Action: All fire door	s in	
					the building were serviced by		
		ons with the Associate			Automated Doors and Access		
		the Director of Campus			Inc. on 5/13/24, and were four	nd to	
		te Health Center Technician			be functioning properly		
		facility from 1:20 p.m. to 4:10 ne latching mechanisms on the			(Attachment A). The doors serving as the entrance to		
	_	rving as the entrance to			independent living from skilled	1	
		in Building I from the			nursing were released from be		
		eatherwood Commons was			"dogged down" immediately. U	_	
		did not latch into the door			further inspection, this door is	-	

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		r í	UILDING	01	COMPL 08/14/	ETED	
	PROVIDER OR SUPPLIER			11050 F	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR APOLIS, IN 46236		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	frame when tested to door in the corridor wall mounted magn release the door with each door was equip and latching hardward door frame. Each door frame. Each door frame. Each door frame of the doctime of the observat Director, the Director the Health Center Tomechanisms being "maintain the 2-hour the skilled nursing windependent living at These findings were Director, the Associan Director of Campus	o close multiple times. Each door set was equipped with a etic releasing device set to h fire alarm system activation, sped with a self-closing device are to latch each door into the cor was also equipped with a stance rating label affixed to the for. Based on interview at the ions, the Associate Executive for of Campus Environment and echnician agreed the latching dogged down" did not fire rated separation between unit and the attached			in a licensed area of the building However, service was request and was provided by Central Sinc. on 8/28/24, and the door is compliance (Attachment B). Ongoing Monitoring: Maintena will be responsible to conduct audits of all fire doors weekly five weeks, and then monthly for 3 months, to ensure that all door are functioning correctly and a issues identified will be address immediately (Attachment C). Audits completed by the maintenance department will be reviewed by the Life Safety Committee during the next quarterly Life Safety Committee determines substate compliance has been achieved.	ed Scale scale s in nce for 4 rs ny ssed see	
K 0324 SS=D Bldg. 01	Ventilation Control Commercial Cooki * residential cookir appliances such a toasters) are used cooking in accorda 19.3.2.5.2 * cooking facilities smoke compartme	IFPA 96, Standard for and Fire Protection of and Fire Protection of ang Operations, unless: ang equipment (i.e., small smicrowaves, hot plates, for food warming or limited ance with 18.3.2.5.2, appen to the corridor in ants with 30 or fewer with the conditions under					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 15 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 08/14/2024 155167 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236 WESTMINSTER VILLAGE NORTH (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 K 0324 Based on record review and interview, the facility K324 - Cooking Facilities 10/01/2024 failed to ensure 2 of 2 kitchen exhaust systems Deficiency: This deficiency was were inspected semiannually. NFPA 96, 2011 cited due to new staff being unable Edition, Standard for Ventilation Control and Fire to locate documentation of the Protection of Commercial Cooking Operations, kitchen exhaust system Section 11.4 states the entire exhaust system shall inspection from 6 months prior to be inspected for grease buildup by a properly 6/4/24 and was therefore trained, qualified, and certified person(s) unavailable for review. acceptable to the authority having jurisdiction Corrective Action: Nelbud, the and in accordance with Table 11.4. Table 11.4, company that services our kitchen Schedule for Inspection for Grease Buildup, exhaust was contacted and sent requires systems serving moderate volume over the previous reports dated cooking operations shall be inspected 1/9/24 (Attachment R), they also semiannually. NFPA 96, 11.6.1 states, upon included reports from 6/8/23 that inspection, if the exhaust system is found to be the Maintenance Director will keep contaminated with deposits from grease laden for his records. Nelbud is vapors, the contaminated portions of the exhaust scheduled for a 6-month system shall be cleaned by a properly trained, inspection in December of this qualified, and certified person(s) acceptable to the year. authority having jurisdiction. Hoods, grease Ongoing Monitoring: Maintenance removal devices, fans, ducts, and other will be responsible for maintaining appurtenances shall be cleaned to remove a spreadsheet that lists all annual, combustible contaminants prior to surfaces and semi-annual inspections, due becoming heavily contaminated with grease or dates, vendors, completion dates oily sludge. After the exhaust system is cleaned, it and where the documentation is shall not be coated with powder or other stored. In addition, these substance. When an exhaust cleaning service is inspections will be scheduled in used, a certificate showing the name of the WorxHub, the maintenance servicing company, the name of the person workorder system, to ensure performing the work, and the date of inspection or proper timing of all inspections. cleaning shall be maintained on the premises. The facility will maintain proper

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 16 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		A. BUILDING B. WING	<u>01</u>	COMPLETED 08/14/2024	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD O PRESBYTERIAN DR	
WESTMI	NSTER VILLAGE N	ORTH	INDIA	ANAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This deficient practi staff.	ice could affect all kitchen		documentation of all future inspections to ensure records available for review	are
	Findings include:				
	inspection contractor documentation dated Executive Director, Environment and the during record review 08/14/24, document system inspections available for review time of record reviee Environment stated facility has two kitch just started working was unaware of the exhaust system inspections six mon available for review	d 06/04/24 with the Associate the Director of Campus e Health Center Technician w from 9:30 a.m. to 1:00 p.m. on tation of kitchen exhaust six prior to 06/04/24 was not be. Based on interview at the w, the Director of Campus the health care portion of the hens with exhaust systems, he at the facility recently and status semi-annual kitchen sections and agreed itchen exhaust system ths prior to 06/04/24 was not			
	Director, the Associ Director of Campus	ate Executive Director, the Environment and the Health			
	3.1-19(b)	during the exit conference.			
K 0345 SS=F Bldg. 01	in accordance with complying with the	-			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 17 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155167		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIER		11050	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR JAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
TAG	National Fire Alar Records of syster and testing are re 9.6.1.3, 9.6.1.5, N Based on record revision failed to maintain 1 accordance with NI Code as required by 9.6. NFPA 72, Sec otherwise permitted shall be performed schedules in Table by the authority has states that the followinspected semi-ann a. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op This deficient pract staff and visitors. Findings include: Based review of the contractor's "Inspect documentation date Executive Director, Environment and the during record reviewo8/14/24, visual serinspection documentation docume	m and Signaling Code. n acceptance, maintenance adily available. IFPA 70, NFPA 72 view and interview, the facility of 1 fire alarm systems in FPA 72, National Fire Alarm y LSC Sections 19.3.4.5.1 and tion 14.3.1 states that unless 1 by 14.3.2, visual inspections in accordance with the 14.3.1, or more often if required ving jurisdiction. Table 14.3.1 wing must be visually ually: ble signals ators is (e.g. duct detectors, manual cat detectors, smoke detectors,	K 0345	K345 – Fire Alarm System - Testing and Maintenance Deficiency: This deficiency we cited due to new staff being to locate documentation date months after 10/11/23 for the semi-annual fire alarm system inspection. Corrective Action: AADCO A and Communication System called to perform an inspectimediately, which was completed on 8/15/24 (Attachment D). No concern were noted. Ongoing Monitoring: To ensicompliance, the next semi-a inspection is already schedul April 2025. Maintenance will responsible for maintaining a spreadsheet that lists all annual semi-annual inspections dates, vendors, completion of and where the documentation stored. In addition, these inspections will be scheduled WorxHub, the maintenance workorder system, to ensure proper timing of all inspection. The facility will maintain proping documentation of all future inspections to ensure record available for review.	- 10/01/2024 vas unable ed 6 e em Alarm as was ion as ure anual, be dates on is d in e ans. oer

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155167	B. WING		08/14/2024
	ROVIDER OR SUPPLIER		1105	EET ADDRESS, CITY, STATE, ZIP COD 50 PRESBYTERIAN DR IANAPOLIS, IN 46236	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	BROWDENIA WAY OF CONDECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	documentation for the six months after 10/review. These findings were Director, the Association Director of Campus	emi-annual inspection the facility's fire alarm system 11/23 was not available for the reviewed with the Executive tate Executive Director, the Environment and the Health thuring the exit conference.			
	3.1-19(b)				
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on record rev failed to maintain at accordance with NF	supply source RKS information on non-required or partial r system.	K 0353	K353 – Sprinkler System – Maintenance and Testing Deficiency: This deficiency w cited due to the lack of	10/01/2024
	maintained in according for the Inspection, T	dance with NFPA 25, Standard Cesting, and Maintenance of rotection Systems. NFPA 25,		documentation regarding the year sprinkler testing. Corrective Action: Supporting	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $9H7H21 \qquad {\tt Facility\ ID:} \quad 000084$

If continuation sheet Page 19 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIER		11050	ADDRESS, CITY, STATE, ZIP CO PRESBYTERIAN DR NAPOLIS, IN 46236	D
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ection (X5) DULD BE PROPRIATE (X5) COMPLETION DATE
TAG	2011 Edition, Secti sprinklers that have shall be replaced or be tested and then r NFPA 25, Section owner or designate or repair deficiencing found during the in required by this starshall be performed personnel or a quality. And the starshall be performed personnel or a quality and the starshall be performed personnel or a quality. It is a components and shauthority having jurity deficient practice of staff, and visitors in Juniper Commons. Findings include: Based on review of inspection contractors and shauthority having jurity deficient practice of staff, and visitors in Juniper Commons. Findings include: Based on review of inspection contractors are documental Associate Executive Campus Environmental Technician during in 1:00 p.m. on 08/14. Heatherwood Communication report stars are due for UL testing sprinkler system in Inspection Report also stated dry sprinkler system in Inspection Report also stated dry sprinkler replacemental due for replacemental due for replacemental replacemental dry sprinkler system in Inspection Report also stated dry sprinkler replacemental due for replacemental due for replacemental dry sprinkler system in Inspection Report also stated dry sprinkler replacemental dry sprinkler replacemental due for replacemental dry sprinkler system in replacemental dry sprinkler replacemental dry sprinkl	the sprinkler system all be made available to the risdiction upon request. This build affect over 50 residents, a Heatherwood Commons and The Piector of the sprinkler system for's "Sprinkler Inspection tion dated 11/27/23 with the eDirector, the Director of the that the Health Center record review from 9:30 a.m. to 24, dry sprinkler sinstalled in mons and Juniper Commons are to 10-year testing. The ises" section of the 11/27/23 ated "Heatherwood dry drops are documentation dated 02/09/24	TAG	documentation has beer stating that samples were by Johnson Controls on the report is provided (AE). The sprinkler system compliance with all regular requirements. Ongoing Monitoring: Mai will be responsible for mai a spreadsheet that lists and semi-annual inspect dates, vendors, complet and where the document stored. In addition, these inspections will be sched WorxHub, the maintenant workorder system, to en proper timing of all inspections to ensure reavailable for review.	n found re taken 12/18/23, Attachment n is in Illatory Inintenance naintaining all annual, Itions, due Ition dates Intation is Ite Iduled in Ince Issure Issure Ite ections. In proper Ince Ince Issure Ite ections. In proper Ince Ite ections Ite e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $9H7H21 \qquad {\tt Facility\ ID:} \quad 000084$

If continuation sheet

Page 20 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIE		11050	r address, city, state, zip co DPRESBYTERIAN DR NAPOLIS, IN 46236	OD.
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION PROPRIATE
K 0363 SS=E Bldg. 01	inspection report s are due for 10 year edition" and "Junip year testing per NI on interview at the Director of Campus started working at unaware of the start testing and agreed of dry sprinkler 10 was not available for These findings were Director, the Asson Director of Campus Center Technician 3.1-19(b) NFPA 101 Corridor - Doors Corridor - Doors Doors protecting than required end exits, or hazardor of smoke and are solid-bonded correcting than required end exits, or hazardor of smoke and are solid-bonded correcting than required end exits, or hazardor of smoke and are solid-bonded correcting than required end exits, or hazardor of smoke and are solid-bonded correcting than required end exits, or hazardor of smoke and are solid-bonded correcting than required end exits, or hazardor of smoke and are solid-bonded correcting than required end capable of resisting minutes. Doors in compartments ar passage of smok to rooms containing combustible mate hardware. Roller CMS regulation. apply to auxiliary flammable or correction Clearance betwe covering is not ex	corridor openings in other closures of vertical openings, us areas resist the passage made of 1 3/4 inch e wood or other material ng fire for at least 20 in fully sprinklered smoke e only required to resist the e. Corridor doors and doors	TAG		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 21 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED 08/14/2024	
		155167	B. W	ING		08/14/	2024
	PROVIDER OR SUPPLIER			11050 F	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR APOLIS, IN 46236		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SURFERENCED TO THE APPROPRIATE CO	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the door closed w applied. There is closing of the doo release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK	device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are ed protective plates of re permitted. Dutch doors 6 are permitted. Door beled and made of steel or compliance with 8.3, compartment is fire window assemblies are n sprinklered compartments ctions in area or fire s or frames in window Parts 403, 418, 460, 482, KS details of doors such as ngs, automatics closing					
	failed to ensure 1 of sleeping rooms in A impediment to closi frame and would re. This deficient pract residents, staff and resident sleeping Re. Findings include: Based on observation Executive Director, Environment and the during a tour of the p.m. on 08/14/24, the corridor door to residents in A. S.	on and interview, the facility of 30 corridor doors to resident aspen Commons had no ing and latching into the door sist the passage of smoke. ice could affect over 10 visitors in the vicinity of oom 3221 in Aspen Commons. ons with the Associate the Director of Campus he Health Center Technician facility from 1:20 p.m. to 4:10 he latching mechanism for the ident sleeping Room 3221 in held to latch into the latching	K 0	363	K363 – Corridor - Doors Deficiency: This deficiency wa cited due to 1 of 30 corridor do to resident sleeping rooms in Aspen Commons not latching properly. Corrective Action: The door fo Aspen Room 3221 was adjust on the same day and is curren latching properly. Ongoing Monitoring: Maintena will be responsible to conduct audits of all resident room doo weekly for 4 weeks, and then monthly for 3 months, to ensur that all doors are functioning correctly and any issues identification.	r ed httly nnce ors	10/01/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084 If continuation sheet Page 22 of 36

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 08/14/2024	
	PROVIDER OR SUPPLIER		11050	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR NAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0521 SS=F Bldg. 01	multiple times. Bas the observations, the agreed the aforemer impediment to latch would not resist the These findings were Director, the Associ Director of Campus Center Technician of 3.1-19(b) NFPA 101 HVAC HVAC Heating, ventilatio comply with 9.2 ar accordance with the specifications. 18.5.2.1, 19.5.2.1, Based on record rev interview; the facili dampers in the facil provided necessary	e reviewed with the Executive late Executive Director, the Environment and the Health during the exit conference. In, and air conditioning shall and shall be installed in the manufacturer's 9.2 iew, observation and try failed to ensure all fire ity were inspected and maintenance within the most	K 0521	(Attachment F) Audits completed by the maintenance department will reviewed by the Life Safety Committee during the next quarterly Life Safety Committee meeting, or until the Life Safety Committee determines substate compliance has been achieved. K521 – HVAC Deficiency: This deficiency was cited due to an itemized listing the results of the facility fire	ty antial ad. 10/01/2024 as g of
	90A. LSC 9.2.1 recair conditioning (H'equipment shall be Standard for the Instand Ventilating System Edition, Section 5.4 maintained in accorfor Fire Doors and ONFPA 80, 2010 Edidamper shall be test installation. The test shall be every 4 years.	iod in accordance with NFPA quires heating, ventilating and VAC) ductwork and related in accordance with NFPA 90A, tallation of Air-Conditioning tems. NFPA 90A, 2012 8.1 states fire dampers shall be dance with NFPA 80, Standard Other Opening Protectives. tion, Section 19.4.1 states each ed and inspected 1 year after st and inspection frequency rs. If the damper is equipped the link shall be removed for		damper inspection and testing documentation within the most recent four-year period could be found for review. Additional fire damper locations in the at did not have inspection sticke affixed to them, and therefore could not be ensured that thost fire dampers had been inspection and tested within the most recent four-year inspection period. Corrective Action: The itemized listing of the facility fire dampers inspection and testing	oft not not not not not not not not not no

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084

If continuation sheet

Page 23 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		ľ í	UILDING	onstruction 01	(X3) DATE COMPI 08/14 ,	LETED	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR	•	
WESTMI	NSTER VILLAGE N	NORTH		1	IAPOLIS, IN 46236		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ll closure and lock-in-place if			documentation date 4/7/21 ha	s	
		lamper shall not be blocked			been located and is provided		
		way. All inspections and			(Attachment G). SafeCare wa		
	_	umented, indicating the			contacted immediately to prov		
		damper, date of inspection,			imspection services on the 3 f		
	_	and deficiencies discovered.			dampers that did not have stic		
		shall have a space to indicate			provided. The inspection took		
		deficiencies were corrected.			place on 8/29/24 and the repo		
		es full unobstructed access to			provided (Attachment H.1). To		
		ll be verified and corrected as			ensure continued compliance	а	
	required. This deficient practice could affect all				4-year inspection is already		
	residents, staff and	VISITORS.			scheduled for April 2025 and	email	
	E' 1' ' 1 1				conformation is provided.		
	Findings include:				(Attachment H.2)		
	Događan nagonil na	view with the Associate			Ongoing Monitoring: Maintena		
		, the Director of Campus			will be responsible for maintai	ning	
		ne Health Center Technician			a spreadsheet that lists all		
		:00 p.m. on 08/14/24, an itemized			required inspections, due date vendors, completion dates and		
		s of facility fire damper			where the documentation is	J	
	-	ng documentation within the			stored. In addition, these		
	_	ear period was not available for			inspections will be scheduled	in	
	-	observations with the			WorxHub, the maintenance		
		e Director, the Director of			workorder system, to ensure		
		ent and the Health Center			proper timing of all inspections	3	
	_	a tour of the facility from 1:20			The facility will maintain prope		
		n 08/14/24, the fire damper			documentation of all future		
		or had affixed inspection			inspections to ensure records	are	
	stickers to fire dam	per locations ceiling			available for review.		
	throughout the faci	lity which were dated July					
	2021. All fire dam	pers locations had current					
	inspection stickers	affixed to the fire damper					
	location except three	ee fire damper locations in the					
	attic. Two of the th	nree fire damper locations were					
	noted in HVAC du	ctwork which penetrated the					
	attic smoke barrier	wall next to the 1-hour fire					
		or above Aspen Commons.					
		e two fire dampers were					
	accessed using the	ladder to the attic in the room					
	across from Room	3212 in Aspen Commons. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084

If continuation sheet Page 24 of 36

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 08/14/2024			
	ROVIDER OR SUPPLIER		11050	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR IAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	(X5) COMPLETION DATE
K 0911 SS=E Bldg. 01	third fire damper lod ductwork which per wall next to the 1-he above Aspen Commatrium. The location accessed using the least by Room 3225 in A interview at the time. Health Center Technensured the aforemed locations in the attick within the most reconstruction of Campus Center Technician of the second Director of Campus Center	cation was also in HVAC netrated the attic smoke barrier our fire resistance rated door nons on the other side of the n of the third fire damper was adder to the attic in the room spen Commons. Based on e of the observations, the nician agreed it could not be entioned three fire damper e were inspected and tested ent four year period. The reviewed with the Executive state Executive Director, the Environment and the Health during the exit conference. The Other as - Other as - Other as Systems requirements assed by the provided efficient. This information, dicable Life Safety Code or eation, should be included as 7.	K 0911	K911 – Electrical Systems - Other Deficiency: This deficiency wa cited due to three trash bins b placed against the wall below mounted electrical panels, wit the working space of the room Corrective Action: The three to	eing wall hin n. rash

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084

If continuation sheet

Page 25 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC		ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155167	B. W	ING		08/14/	2024
				CTREET	ADDRESS SITE OF THE SOL		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
VA/EOTA4	NOTED VIII A OF A	IODTII			PRESBYTERIAN DR		
WESTMI	NSTER VILLAGE N	IORTH		INDIAN	APOLIS, IN 46236		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		T.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION				16	DATE
	equipment to permi	t ready and safe operation and			electrical panels immediately.		
		h equipment. Working space			Ongoing Monitoring: Maintena	nce	
		ating at 600 volts, nominal, or			will be responsible for conduct		
		quire examination, adjustment,			audits of all working spaces	9	
	1	enance while energized shall			adjacent to electrical panels		
	T	mensions of 110.26(A) (1), (2)			weekly for 4 weeks, and then		
		(1) states the depth of the			monthly for 3 months thereafte	er. to	
		e direction of live parts shall			ensure that no items are	,	
		t specified in Table 110.26(A)			obstructing access to the pane	els.	
		num clear distance is 3 feet.			Any issues identified will be	· -	
	1 1	2) states the width of the			addressed immediately and st	aff	
		ont of the electrical equipment			will be re-educated on the		
		of the equipment or 762 mm (30			importance of keeping these a	reas	
		reater. In all cases, the work			clear. (Attachment J)		
		at least a 90 degree opening of			All Maintenance Department		
		hinged panels. 110.26(A)(3)			personnel will be educated		
		ce shall be clear and extend			regarding the requirements for		
	_	or, or platform to a height of 6			mechanical rooms.		
	_	neight of the equipment,			Audits completed by the		
		r. Article 110.26(B) states the			maintenance department will b	ре	
	_	ired by this section shall not			reviewed by the Life Safety		
		This deficient practice could			Committee during the next		
	affect over 10 resid	ents, staff and visitors in the			quarterly Life Safety Committe	e	
	vicinity of the Mecl	hanical Room inside the			meeting, or until the Life Safet		
	Heatherwood Com	mons Dining Room/Activities			Committee determines substa	-	
	Room.				compliance has been achieved	d	
	Findings include:						
	Based on observation	ons with the Associate					
	Executive Director,	the Director of Campus					
	Environment and th	ne Health Center Technician					
	during a tour of the	facility from 1:20 p.m. to 4:10					
		hree trash cans were placed up					
	1 -	derneath the wall mounted					
	l -	entified as "KXC Sect. 1" and					
	_	ne Mechanical Room inside the					
	Heatherwood Com	mons Dining Room/Activities					
		rash cans were stored within					
	the working space i	n front of the electrical panels					
	I ~ ~ 1	1	1		i		ı

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $9H7H21 \qquad {\tt Facility\ ID:} \quad 000084$

If continuation sheet Page 26 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 155167 B. WING			(X3) DATE SURVEY COMPLETED 08/14/2024		
NAME OF P	PROVIDER OR SUPPLIER		 STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
	NSTER VILLAGE N			PRESBYTERIAN DR APOLIS, IN 46236		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N OF CORRECTION	
PREFIX	-	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	in the room. Based observations, the Hoagreed the aforement within the working panels in the room. These findings were Director, the Association of Campus	on interview at the time of the ealth Center Technician ntioned items were stored space in front of the electrical ereviewed with the Executive ate Executive Director, the Environment and the Health during the exit conference.	TAG	DEFEREN		DATE
	3.1-19(b)					
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and whe anesthesia is adminitial installation, and ditional testing in defined by docume Receptacles not list these locations are exceeding 12 more (LIM), if installed, alless than or equal the LIM test switch activates both visual LIM circuits with a manual test is performed to 12 tested per 6.3.3.3. renovation to the Records are maintrassociated repairs	s - Maintenance and septacles at patient bed re deep sedation or general inistered, are tested after replacement or servicing. is performed at intervals ented performance data. sted as hospital-grade at the tested at intervals not on this. Line isolation monitors have tested at intervals of to 1 month by actuating on per 6.3.2.6.3.6, which hal and audible alarm. For the tested at intervals less commoths. LIM circuits are 2 after any repair or electric distribution system. tained of required tests and for modifications, form or area tested, and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $9H7H21 \qquad {\tt Facility\ ID:} \quad 000084$

If continuation sheet

Page 27 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155167	l í	JILDING	ONSTRUCTION 01	(X3) DATE : COMPL 08/14/	ETED
	PROVIDER OR SUPPLIER			11050 F	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR IAPOLIS, IN 46236		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY 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)	ATE	(X5) COMPLETION DATE
	interview; the facility documentation of extesting for all reside available for review NFPA 99, Health CE Edition, Section 6.3 listed as hospital-grand in locations who anesthesia shall be exceeding 12 month Facilities Code, 20 states hospital-grad performed after initis servicing of the dex Receptacle Testing the physical integric confirmed by visual the grounding circuis shall be verified. Concutral connections shall be confirmed; grounding blade of (except locking-typthan 115 grams (4 constants) states, at a minimum date, the rooms or a of which items have the performance reconstruction of the performance re	lectrical outlet receptacle ent sleeping rooms was in accordance with NFPA 99. lare Facilities Code, 2012 6.4.1.3 states receptacles not ade at patient bed locations ere deep sedation or general tested at intervals not ins. NFPA 99, Health Care 12 Edition, Section 6.3.4.1.1 ereceptacles testing shall be ial installation, replacement or rice. Section 6.3.3.2, in Patient Care Rooms requires by of each receptacle shall be I inspection. The continuity of it in each electrical receptacle forrect polarity of the hot and in each electrical receptacle and retention force of the each electrical receptacle ereceptacles) shall be not less bunces). Section 6.3.4.2.1.2 in, the record shall contain the ireas tested, and an indication ere, or have failed to meet, quirements of this chapter. I residents.	K 0	914	K914 –Electrical Systems – Maintenance and Testing Deficiency: This deficiency way cited due to documentation showing testing of electrical receptacles in residents room within the last twelve month purcould not be located, and their was not available for review. Corrective Action: To ensure compliance, an inspection of resident room electrical receptacles was completed on 8/29/24 to ensure that recepta are functioning properly and resident standards. (Attachmen Ongoing Monitoring: Following initial inspection, maintenance be responsible to conduct quarterly spot audits of electrical receptacles in resident rooms one year. Any issues identified be addressed immediately. (Attachment L) Audits completed by the maintenance department will reviewed by the Life Safety Committee during the next quarterly Life Safety Committee determines substated compliance has been achieved.	s eriod refore all n acles neet at K) g the e will cal for d will be ee ety antial	10/01/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 28 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		r í	ILDING	01	COMPL 08/14/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR		
WESTMI	NSTER VILLAGE N	ORTH		INDIAN	APOLIS, IN 46236		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
₩ 0018	testing documentation rooms within the mode was not available for documentation was Based on interview the Health Center To a while to complete and agreed electrical testing documentation rooms for the most in was not available for observations with the Director, the Director, the Director, the Health Center To facility from 1:20 p. resident sleeping room receptacles installed. These findings were Director, the Associ Director of Campus Center Technician documents.	ne Associate Executive or of Campus Environment and echnician during a tour of the m. to 4:10 p.m. on 08/14/24, all oms had non-hospital-grade					
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical and testing of the se	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ated equipment is capable be within 10 seconds. If the n is not met during the nocess shall be provided to nis capability for the life branches. Maintenance generator and transfer formed in accordance with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 29 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155167	B. WI			08/14/2024		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR			
WESTMI	NSTER VILLAGE N	NORTH			IAPOLIS, IN 46236			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		e inspected weekly,						
		oad 30 minutes 12 times a						
		intervals, and exercised						
	1	onths for 4 continuous hours.						
		nder load conditions include						
	a complete simula							
		ual transfer of all EES						
		nducted by competent						
		enance and testing of stored						
		rces (Type 3 EES) are in						
	accordance with NFPA 111. Main and feeder							
		re inspected annually, and a						
	program for periodically exercising the components is established according to							
		uirements. Written records nd testing are maintained						
		ble. EES electrical panels						
		arked, readily identifiable,						
		n normal power circuits.						
	-	ssibility of damage of the						
		source is a design						
	consideration for i	_						
		(NFPA 99), NFPA 110,						
	NFPA 111, 700.10							
	I	review and interview, the	K 09	918	K918 – Electrical Systems –		10/01/2024	
	facility failed to exe	ercise 3 of 3 generators for 1			Essential Electric System			
	month of the most i	recent 12 month period to meet			Maintenance and Testing			
	the requirements of	NFPA 110, 2010 Edition, the			Deficiency: This deficiency wa	as		
	Standard for Emerg	gency and Standby Powers			cited due to (1) generator load	d		
		.4.2. NFPA 110, Section 8.4.2			testing from July 2024 for three	ee	1	
		tor sets in service shall be			generators not being available	e for		
		nce monthly, for a minimum of			review. (2) documentation from			
	_	one of the following methods:			annual fuel quality testing for			
		aintains the minimum exhaust			generators within the most red			
	,	recommended by the			twelve-month period not being	g		
	manufacturer				available for review. (3)			
		g temperature conditions and at			documentation from emergen	су		
	_	cent of the EPS (Emergency			testing for 3 of 3 generators			
	Power Supply) nam	-			showing 4 continuous hours of			
	I Section 8.4.2.3 state	es diesel-powered EPS	1		load testing withing the last 36	3	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21 Facility ID: 000084 If continuation sheet Page 30 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIEI		11050	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR JAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIADEFICIENCY)	(X5) COMPLETION DATE
	installations that do 8.4.2 shall be exerce EPSS (Emergency shall be exercised a loads (Load Bank Tof the EPS namepla minutes and at not nameplate kW ratir total test duration of hours. This deficie residents, staff and Findings include: Based on review of Minute Monthly Tof the Associate Exec Campus Environme Technician during 1:00 p.m. on 08/14, for July 2024 was ron interview at the Health Center Techportion of the facility generators, he perfoduring July 2024 for agreed monthly load July 2024 was not at These findings were Director, the Associate Technician of Campus Center Technician of 3.1-19(b) 2. Based on record	o not meet the requirements of ised monthly with the available Power Supply System) load and innually with supplemental Fest) at not less than 50 percent ate kW rating for 30 continuous less than 75 percent of the EPS ag for 1 continuous hour for a f not less than 1.5 continuous nt practice could affect all		months no being available for review. Corrective Action: (1) The intermonthly generator exercise refor all three generators for Julbeen located and is provided (Attachment M). The generatexercise report for August is a provided to demonstrate compliance. (Attachment M). audit will be conducted month 6 months to ensure ongoing compliance. (Attachment N) (2) The annual fuel quality tesbeen located and is provided (Attachment O), completed be MacAllister on 6/18/24. (3) The 36-month emergency generator testing for all three generators has been located is provided (Attachment P), including both a 2-hour load to and a 4-hour load test, compleby MacAllister on 6/7/24. Ongoing Monitoring: Ongoing Monitoring: Maintenance will ensure that all generator testing and fuel quality checks are conducted on schedule and properly documented. Maintenance will be responsite for maintaining a spreadsheet lists all annual and semi-annuinspections, due dates, vendocompletion dates and where the documentation is stored. In addition, these inspections wischeduled in WorxHub, the	ernal eport y has or also An ally for st has y and est eted or that ial ors, the
	•	the facility's three diesel fuel		maintenance workorder syste	m to

fired emergency generators. NFPA 99, Health

ensure proper timing of all

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155167	A. BUILDING B. WING	01	COMPLETED 08/14/2024
	ROVIDER OR SUPPLIER NSTER VILLAGE N		11050	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR NAPOLIS, IN 46236	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SE COMPLETION DATE
TAG	Care Facilities Code 6.5.4.1.1.2 states Ty System) generator's tested in accordance Section 6.4.4.1.1.3 s performed in accord for Emergency and Edition, Chapter 8. a fuel quality test sh annually using tests standards. This defi residents, staff and of Findings include: Based on record rev Executive Director, Environment and th from 9:30 a.m. to 1: documentation of at the facility's three d generators within th period was not avail interview at the time Center Technician s of the facility has th generators and agree annual fuel quality to within the most rece not available for rev These findings were Director, the Associ Director of Campus Center Technician of	e, 2012 Edition, Section Type 2 EES (Essential Electrical Type 3 Estates Type 4 Estates Type 4 Estates Type 4 Estates Type 4 Estates Type 5 Estates Type 6 Estates Type 6 Estates Type 6 Estates Type 7 Estates Type 7 Estates Type 7 Estates Type 8 Estates Type 8 Estates Type 9 Estates	TAG	inspections. The facility will maintain proper documenta all future inspections to ensirecords are available for rev	tion of ure
	facility failed to doc	cument 36 month period			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 32 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155167		(X2) MULTIPLE O A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED ON (14/2004	
		155167	B. WING		08/14/2024
	PROVIDER OR SUPPLIE		11050	ADDRESS, CITY, STATE, ZIP C PRESBYTERIAN DR NAPOLIS, IN 46236	OD
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE COMIT ELTION
TAG		or LSC IDENTIFYING INFORMATION tor testing for 3 of 3 emergency	TAG	DEFICIENC!)	DATE
		rdance with NFPA 99 and			
		A 99, Health Care Facilities Code,			
		tion 6.4.1.1.6.1 states Type 1 and			
		lectrical system power sources			
		assified as Type 10, Class X,			
		sets per NFPA 110. NFPA 110,			
	_	mergency and Standby Powers			
	Systems, 2010 Edi	ition, Section 8.4.9 states Level 1			
		ed at least once within every 36			
		4.4.9.1 states Level 1 EPSS shall			
		usly for the duration of its			
		e Section 4.2). Section 8.4.9.2			
		ssigned class is greater than 4			
	_	ermitted to terminate the test			
		hours. Section 8.4.9.5 states			
		for this test shall be specified in			
		2, or 8.4.9.5.3. Section 8.4.9.5.1			
		powered EPS, loading shall be creent of the nameplate kW			
	_	A supplemental load bank shall			
	_	used to meet or exceed the 30			
	_	nt. Section 8.4.9.5.2 states for a			
	1 -	S, loading shall be that which			
	_	mum exhaust gas temperatures			
		by the manufacturer. Section			
	8.4.9.5.7 states wh	here the test required in 8.4.9 is			
	combined with the	annual load bank test, the first			
	3 hours shall be at	not less than the minimum			
		y 8.4.9.5 and the remaining hour			
		than 75 percent of the			
	_	ng of the EPS. This deficient			
	1 -	ect all residents, staff and			
	visitors.				
	Findings include:				
	Based on record re	eview with the Associate			
		r, the Director of Campus			
		the Health Center Technician			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 33 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155167	B. WI	NG		08/14/	2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				PRESBYTERIAN DR		
WESTMII	NSTER VILLAGE N	ORTH			APOLIS, IN 46236		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	w from 9:30 a.m. to 1:00 p.m. on					
		month period emergency					
	-	four continuous hours for					
		iesel fired emergency					
	-	available for review. Based on					
		e of record review, the Health					
		tated the health care portion					
	•	ree diesel fuel fired emergency					
	-	ed thirty-six month period or testing for four continuous					
		y's three diesel fired emergency					
		available for review.					
	generators was not t	ivaliable for review.					
	These findings were	e reviewed with the Executive					
	_	ate Executive Director, the					
		Environment and the Health					
	-	luring the exit conference.					
	3.1-19(b)						
K 0920	NFPA 101						
SS=E		ent - Power Cords and					
Bldg. 01	Extens						
	Electrical Equipme Extension Cords	ent - Power Cords and				ļ	
		patient care vicinity are only					
	used for compone	-					
	•	ed electrical equipment					
	(PCREE) assembl						
		lified personnel and meet					
	the conditions of 1	0.2.3.6. Power strips in					
	the patient care vie	cinity may not be used for					
	non-PCREE (e.g.,	personal electronics),					
		n care resident rooms that					
	do not use PCREE	E. Power strips for PCREE					
		UL 60601-1. Power strips					
		the patient care rooms					
	,) meet UL 1363. In					
	•	ooms, power strips meet					
	other UL standard	s. All power strips are					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9H7H21

Facility ID: 000084

If continuation sheet

Page 34 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/14/2024		
	PROVIDER OR SUPPLIER			11050 F	ADDRESS, CITY, STATE, ZIP COD PRESBYTERIAN DR APOLIS, IN 46236		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC 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
	cords are not used wiring of a structure temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 Based on observation failed to ensure 2 of power strips were not fixed wiring. LSC comply with Section electrical wiring and NFPA 70, National NFPA 70, National NFPA 70, Article 4 specifically permittive shall not be used as a structure. LSC Securice equipment of safety shall be design in accordance with NFPA 99, Standard edition, defines pation of a health care facinatended to be exampled intended for the exampatients, extending location of the bed, device that supports examination and treextends vertically to floor. NFPA 99, Security or office appliances grounding conducted be permitted provide the patient care vicility and the patient care vicil	precautions. Extension d as a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was ts the conditions of 10.2.4. 29), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 on and interview, the facility of 2 extension cords including ot used as a substitute for 19.5.1 requires utilities to n 9.1. LSC 9.1.2 requires d equipment to comply with Electrical Code, 2011 Edition. 00.8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of ection 4.5.7 states any building or safeguard provided for life gned, installed and approved all applicable NFPA standards. For Health Care Facilities, 2012 tent care areas as any portion lity wherein patients are nined or treated. Patient care as a space, within a location unination and treatment of 6 ft (1.8 m) beyond the normal chair, table, treadmill, or other is the patient during statment. A patient care vicinity of 7 ft 6 in. (2.3 m) above the ection 10.4.2.3 states household not commonly equipped with ors in their power cords shall led they are not located within nity. This deficient practice of residents, staff and visitors.	K 0	920	K920 – Electrical Equipment Power Cords and Extension Cords Deficiency: This deficiency wa cited due to 2 of 2 extension cords, including power strips v used as a substitute for fixed wiring in resident rooms. Corrective Action: The power s in Juniper Room 3382 was removed and replaced immediately. Child safety plug are being installed in all reside rooms, including Juniper Roor 3380, where electrical recepta are built into the base of lamps Lamps with electrical recepta in the base will be changed ou over the coming years. Reside and families will be informed v email communication, as well by our Admissions Coordinato the time of admission, that pow strips, multi-plug adapters, and extension cords cannot be use place of fixed wiring in the resident's rooms. Ongoing Monitoring: Audits wi conducted weekly for 4 weeks and then monthly thereafter, to ensure that residents are not using power strips or other	s vere strip s ent n cles s. eles ut ents via as r at wer d d d li be	10/01/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9H7H21

Facility ID: 000084

If continuation sheet

Page 35 of 36

PRINTED: 09/05/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	e construction G <u>01</u>	(X3) DATE SURVEY COMPLETED	
		155167	B. WING		08/14/2024
NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH		110	EET ADDRESS, CITY, STATE, ZIP 50 PRESBYTERIAN DR IANAPOLIS, IN 46236	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION (X5) SHOULD BE APPROPRIATE COMPLETION DATE
	Based on observative Executive Director, the Assoc Director of Campus: Based on observative Executive Director, the Assoc Director of Campus: Based on observative Executive Director, the Assoc Director of Campus: Based on observative Director of Campus: Based on observations, the Director of Campus: Based on interview observations, the Director of Campus: Based on observations of the recept observations of the recept observations of the properties of the two aforements.	ons with the Associate the Director of Campus the Health Center Technician facility from 1:20 p.m. to 4:10 the following was noted: reging cable was plugged into a ton a night stand one foot from Room 3382 in Juniper Listing of the power strip could terry charger device was trical receptacle built into the and one foot from the resident in Juniper Commons. The UL tacle in the lamp could not be that the time of the tirector of Campus the Health Center Technician to were being used in the patient the REE and non-PCREE and was a substitute for fixed wiring at		unauthorized electrical Maintenance will also spot checks during ro to ensure compliance electrical safety stand violations will be corresimmediately, and resistaff will be re-educate electrical safety practical safety practica	al devices. conduct utine rounds with lards. Any ected dents and ed on proper ices. the nent will be Safety next Committee ife Safety s substantial

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9H7H21 Facility ID: 000084 If continuation sheet Page 36 of 36