| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155167 | A. BUILDING -- B. WING | 08/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| WESTMINSTER VILLAGE NORTH | 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 08/14/24<br><br>Facility Number: 000084<br>Provider Number: 155167<br>AIM Number: 100284600<br><br>At this Emergency Preparedness survey, Westminster Village North was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 148 certified beds. At the time of the survey, the census was 111.<br><br>Quality Review completed on 08/19/24<br><br>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: | E 0000 | The submission of this plan of correction shall not be construed as an admission that Westminster 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 services provided in long-term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources to make any adjustments necessary to achieve better outcomes for residents.<br>As required, the facility submits the following plan of correction:<br>Westminster Village North is requesting a desk review of the plans of corrections submitted. | |
| E 0039<br>SS=F<br>Bldg. -- | 403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.542(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)<br>EP Testing Requirements<br>§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) | | | |

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

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| | (2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[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]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(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.<br>(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:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed | | | |

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| | messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(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:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise 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:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed | | | |

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| | to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] | | | |

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| | (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the [PRTF, Hospital, CAH] 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 full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE | | | |

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| | organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise 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:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: | | | |

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| | (i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] 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.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(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:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not | | | |

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| | accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(B) If the HHA experiences an actual | | | |

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| | natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise 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:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that | | | |

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| | requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. | | | |
| | Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>b. If the LTC 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 full-scale | E 0039 | **E039 – Emergency Preparedness**<br>Deficiency: The facility failed to provide documentation of a full-scale, community-based or individual, facility-based functional exercise within the most recent two-year period. Additionally, the facility did not document any actual natural or man-made emergency that required activation of the emergency plan within the same period.<br>Corrective Action:<br>The facility will immediately | 10/01/2024 |

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| | community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or<br>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of "Emergency Operations Plan" documentation dated 08/02/24 with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during record review from 9:30 a.m. to 1:00 p.m. on 08/14/24, documentation for a full-scale exercise that is community-based or an individual, facility-based functional exercise within the most recent two year period was not available for review. The facility also did not document any actual natural or man-made emergency that required activation of the emergency plan within the most recent two year period. No other documentation of testing the facility's emergency plan policies was available for review at the time of the survey. Based on interview at the time of | | coordinate with local emergency management agencies to plan and participate in a full-scale, community-based exercise. A request for a full-scale drill has been sent to the Lawrence Fire Department.<br>Documentation of any future exercises, including objectives, participation, and after-action reports, will be maintained and reviewed by the Emergency Preparedness Committee.<br>Ongoing Monitoring:<br>Quarterly Emergency Drills: The facility will conduct quarterly emergency drills, alternating between different scenarios (e.g., fire, severe weather, power outage) to ensure comprehensive preparedness. These drills will be documented and reviewed by the Emergency Preparedness Committee.<br>Annual Full-Scale Exercise: The facility will ensure participation in at least one, community-based or facility-based functional exercise annually. Documentation of these exercises will be maintained and available for review during future surveys.<br>Audit and Review: The Emergency Preparedness Committee will conduct a bi-annual audit of all emergency preparedness documentation to ensure that all exercises, drills, and any actual emergencies are properly documented. Any deficiencies | |

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| | record review, the Associate Executive Director stated the employee who maintains that documentation for the facility was not currently available and agreed emergency preparedness testing documentation was not available for review at the time of the survey.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference. | | identified will be corrected immediately, and staff will receive additional training as needed.<br>Follow-Up: The results of the audit will be presented to the facility's leadership team, and any recommendations for improvement will be implemented within 30 days.<br>Plan Completion Date: The facility anticipates that all corrective actions will be completed by October 1, 2024. The Emergency 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<br><br>Bldg. 01 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 08/14/24<br><br>Facility Number: 000084<br>Provider Number: 155167<br>AIM Number: 100284600<br><br>At this Life Safety Code survey, Westminster Village North was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, | K 0000 | The submission of this plan of correction shall not be construed as an admission that Westminster 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 services provided in long-term care facilities. We believe that any feedback provided to us should be taken very seriously, and we are committed to using our resources | |

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|---|---|---|---|
| | 155167 | A. BUILDING 01<br>B. WING | 08/14/2024 |

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| WESTMINSTER VILLAGE NORTH | 11050 PRESBYTERIAN DR<br>INDIANAPOLIS, IN 46236 |

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| | Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility with a partial basement consists of Buildings 0101, 0103, 0105, 0106 and 0107. Building 0101, which consists of Willow Commons, Heatherwood Commons, Aspen Commons and Juniper Commons was built in 1974 and was determined to be of Type V (111) construction and fully sprinklered. The Administration Wing, identified as Building 0103, was built in 2005 and was determined to be of Type V (111) construction and fully sprinklered. Cedar Commons, identified as Building 0105 and Aspen Commons, identified as Building 0106 were each built in 2013 and were determined to be of Type V (111) construction and fully sprinklered. The new Dining Room, kitchen and walkway addition to Memory Care, identified as Building 0107, was built in 2014 and was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. All resident sleeping rooms were provided with smoke detectors hard wired to the fire alarm system. The facility has a capacity of 148 and had a census of 111 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review completed on 08/19/24 | | to make any adjustments necessary to achieve better outcomes for residents.<br>As required, the facility submits the following plan of correction:<br>Westminster Village North is requesting a desk review of the plans of corrections submitted. | |
| K 0131<br>SS=E<br>Bldg. 01 | NFPA 101<br>Multiple Occupancies<br>Multiple Occupancies - Sections of Health Care Facilities<br>Sections of health care facilities classified as | | | |

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| | other occupancies meet all of the following:<br><br>o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access.<br>o They are separated from areas of health care occupancies by<br>construction having a minimum two hour fire resistance rating in<br>accordance with Chapter 8.<br>o The entire building is protected throughout by an approved, supervised<br>automatic sprinkler system in accordance with Section 9.7.<br><br>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.<br>19.1.3.3, 42 CFR 482.41, 42 CFR 485.623<br>Based on observation and interview, the facility failed to maintain the 2-hour fire rated separation between the skilled nursing unit and the attached independent living area in accordance with Section 19.1.3.4.1. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from Heatherwood Commons.<br><br>Findings include:<br><br>Based on observations with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during a tour of the facility from 1:20 p.m. to 4:10 p.m. on 08/14/24, the latching mechanisms on the corridor door set serving as the entrance to Independent Living in Building I from the walkway outside Heatherwood Commons was "dogged down" and did not latch into the door | K 0131 | **K131 – Multiple Occupancies**<br>Deficiency: This deficiency was cited due to the latching mechanisms on the corridor door, that serves as the entrance to Independent Living from Skilled Nursing, being “dogged down" and therefore unable to latch onto the door frame.<br>Corrective Action: All fire doors in the building were serviced by Automated Doors and Access, Inc. on 5/13/24, and were found to be functioning properly **(Attachment A).** The doors serving as the entrance to independent living from skilled nursing were released from being “dogged down” immediately. Upon further inspection, this door is not | 10/01/2024 |

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| | frame when tested to close multiple times. Each door in the corridor door set was equipped with a wall mounted magnetic releasing device set to release the door with fire alarm system activation, each door was equipped with a self-closing device and latching hardware to latch each door into the door frame. Each door was also equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of the observations, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician agreed the latching mechanisms being "dogged down" did not maintain the 2-hour fire rated separation between the skilled nursing unit and the attached independent living area.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | in a licensed area of the building. However, service was requested and was provided by Central Scale Inc. on 8/28/24, and the door is in compliance **(Attachment B).**<br>Ongoing Monitoring: Maintenance will be responsible to conduct audits of all fire doors weekly for 4 weeks, and then monthly for 3 months, to ensure that all doors are functioning correctly and any issues identified will be addressed immediately **(Attachment C).**<br>Audits completed by the maintenance department will be reviewed by the Life Safety Committee during the next quarterly Life Safety Committee meeting, or until the Life Safety Committee determines substantial compliance has been achieved. | |
| K 0324<br>SS=D<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or | | | |

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| | * 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.<br>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<br>Based on record review and interview, the facility failed to ensure 2 of 2 kitchen exhaust systems were inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. | K 0324 | **K324 – Cooking Facilities**<br>Deficiency: This deficiency was cited due to new staff being unable to locate documentation of the kitchen exhaust system inspection from 6 months prior to 6/4/24 and was therefore unavailable for review.<br>Corrective Action: Nelbud, the company that services our kitchen exhaust was contacted and sent over the previous reports dated 1/9/24 (Attachment R), they also included reports from 6/8/23 that the Maintenance Director will keep for his records. Nelbud is scheduled for a 6-month inspection in December of this year.<br>Ongoing Monitoring: Maintenance will be responsible for maintaining a spreadsheet that lists all annual, and semi-annual inspections, due dates, vendors, completion dates and where the documentation is stored. In addition, these inspections will be scheduled in WorxHub, the maintenance workorder system, to ensure proper timing of all inspections. The facility will maintain proper | 10/01/2024 |

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| | This deficient practice could affect all kitchen staff.<br><br>Findings include:<br><br>Based on review of the kitchen range hood inspection contractor's "Service Report" documentation dated 06/04/24 with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during record review from 9:30 a.m. to 1:00 p.m. on 08/14/24, documentation of kitchen exhaust system inspections six prior to 06/04/24 was not available for review. Based on interview at the time of record review, the Director of Campus Environment stated the health care portion of the facility has two kitchens with exhaust systems, he just started working at the facility recently and was unaware of the status semi-annual kitchen exhaust system inspections and agreed documentation of kitchen exhaust system inspections six months prior to 06/04/24 was not available for review.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | documentation of all future inspections to ensure records are available for review | |
| K 0345 SS=F Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, | | | |

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| | National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:<br>a. Control unit trouble signals<br>b. Remote annunciators<br>c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)<br>d. Notification appliances<br>e. Magnetic hold-open devices<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based review of the fire alarm system inspection contractor's "Inspection and Testing Form" documentation dated 10/11/23 with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during record review from 9:30 a.m. to 1:00 p.m. on 08/14/24, visual semi-annual fire alarm system inspection documentation six months after 10/11/23 was not available for review. Based on interview at the time of record review, the Director of Campus Environment stated he just started working at the facility recently and was unaware of the status of fire alarm semi-annual inspections | K 0345 | **K345 – Fire Alarm System – Testing and Maintenance**<br>Deficiency: This deficiency was cited due to new staff being unable to locate documentation dated 6 months after 10/11/23 for the semi-annual fire alarm system inspection.<br>Corrective Action: AADCO Alarm and Communication Systems was called to perform an inspection immediately, which was completed on 8/15/24 **(Attachment D).** No concerns were noted.<br>Ongoing Monitoring: To ensure compliance, the next semi-annual inspection is already scheduled for April 2025. Maintenance will be responsible for maintaining a spreadsheet that lists all annual, and semi-annual inspections, due dates, vendors, completion dates and where the documentation is stored. In addition, these inspections will be scheduled in WorxHub, the maintenance workorder system, to ensure proper timing of all inspections. The facility will maintain proper documentation of all future inspections to ensure records are available for review. | 10/01/2024 |

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| | and agreed visual semi-annual inspection documentation for the facility's fire alarm system six months after 10/11/23 was not available for review.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | | |
| K 0353 SS=E Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.<br>Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, | K 0353 | **K353 – Sprinkler System – Maintenance and Testing**<br>Deficiency: This deficiency was cited due to the lack of documentation regarding the 10 year sprinkler testing.<br>Corrective Action: Supporting | 10/01/2024 |

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| | 2011 Edition, Section 5.3.1.1.1.6 states dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect over 50 residents, staff, and visitors in Heatherwood Commons and Juniper Commons.<br><br>Findings include:<br><br>Based on review of the sprinkler system inspection contractor's "Sprinkler Inspection Report" documentation dated 11/27/23 with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during record review from 9:30 a.m. to 1:00 p.m. on 08/14/24, dry sprinklers installed in Heatherwood Commons and Juniper Commons are due for replacement or 10-year testing. The "General Deficiencies" section of the 11/27/23 inspection report stated "Heatherwood dry drops are due for UL testing" and "Juniper dry drops are due for UL testing". In addition, review of the sprinkler system inspection contractor's "Sprinkler Inspection Report" documentation dated 02/09/24 also stated dry sprinklers installed in Heatherwood Commons and Juniper Commons are due for replacement or 10-year testing. The "General Deficiencies" section of the 02/09/24 | | documentation has been found stating that samples were taken by Johnson Controls on 12/18/23, the report is provided **(Attachment E).** The sprinkler system is in compliance with all regulatory requirements.<br>Ongoing Monitoring: Maintenance will be responsible for maintaining a spreadsheet that lists all annual, and semi-annual inspections, due dates, vendors, completion dates and where the documentation is stored. In addition, these inspections will be scheduled in WorxHub, the maintenance workorder system, to ensure proper timing of all inspections. The facility will maintain proper documentation of all future inspections to ensure records are available for review. | |

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| | inspection report stated "Heatherwood dry drops are due for 10 year testing per NFPA 25, 2011 edition" and "Juniper dry drops are due for 10 year testing per NFPA 25, 2011 edition". Based on interview at the time of record review, the Director of Campus Environment stated he just started working at the facility recently and was unaware of the status of dry sprinkler 10 year testing and agreed documentation of the results of dry sprinkler 10 year testing on or after 11/27/23 was not available for review.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | | |
| K 0363<br>SS=E<br>Bldg. 01 | NFPA 101<br>Corridor - Doors<br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible | | | |

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| | if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. | | | |
| | Based on observation and interview, the facility failed to ensure 1 of 30 corridor doors to resident sleeping rooms in Aspen Commons had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 3221 in Aspen Commons.<br><br>Findings include:<br><br>Based on observations with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during a tour of the facility from 1:20 p.m. to 4:10 p.m. on 08/14/24, the latching mechanism for the corridor door to resident sleeping Room 3221 in Aspen Commons failed to latch into the latching | K 0363 | **K363 – Corridor - Doors**<br>Deficiency: This deficiency was cited due to 1 of 30 corridor doors to resident sleeping rooms in Aspen Commons not latching properly.<br>Corrective Action: The door for Aspen Room 3221 was adjusted on the same day and is currently latching properly.<br>Ongoing Monitoring: Maintenance will be responsible to conduct audits of all resident room doors weekly for 4 weeks, and then monthly for 3 months, to ensure that all doors are functioning correctly and any issues identified will be addressed immediately. | 10/01/2024 |

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| WESTMINSTER VILLAGE NORTH | 11050 PRESBYTERIAN DR<br>INDIANAPOLIS, IN 46236 |

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| | plate late on the door frame when tested to close multiple times. Based on interview at the time of the observations, the Health Center Technician agreed the aforementioned corridor door had an impediment to latching into the door frame and would not resist the passage of smoke.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | **(Attachment F)**<br>Audits completed by the maintenance department will be reviewed by the Life Safety Committee during the next quarterly Life Safety Committee meeting, or until the Life Safety Committee determines substantial compliance has been achieved. | |
| K 0521<br>SS=F<br>Bldg. 01 | NFPA 101<br>HVAC<br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br>Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance within the most recent four year period in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for | K 0521 | **K521 – HVAC**<br>Deficiency: This deficiency was cited due to an itemized listing of the results of the facility fire damper inspection and testing documentation within the most recent four-year period could not be found for review. Additionally, 3 fire damper locations in the attic did not have inspection stickers affixed to them, and therefore it could not be ensured that those 3 fire dampers had been inspected and tested within the most recent four-year inspection period.<br>Corrective Action: The itemized listing of the facility fire damper inspection and testing | 10/01/2024 |

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| | testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. Section 19.4.3 states full unobstructed access to the fire damper shall be verified and corrected as required. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician from 9:30 a.m. to 1:00 p.m. on 08/14/24, an itemized listing of the results of facility fire damper inspection and testing documentation within the most recent four year period was not available for review. Based on observations with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during a tour of the facility from 1:20 p.m. to 4:10 p.m. on 08/14/24, the fire damper inspection contractor had affixed inspection stickers to fire damper locations ceiling throughout the facility which were dated July 2021. All fire dampers locations had current inspection stickers affixed to the fire damper location except three fire damper locations in the attic. Two of the three fire damper locations were noted in HVAC ductwork which penetrated the attic smoke barrier wall next to the 1-hour fire resistance rated door above Aspen Commons. The locations of the two fire dampers were accessed using the ladder to the attic in the room across from Room 3212 in Aspen Commons. The | | documentation date 4/7/21 has been located and is provided **(Attachment G).** SafeCare was contacted immediately to provide imspection services on the 3 fire dampers that did not have stickers provided. The inspection took place on 8/29/24 and the report is provided **(Attachment H.1).** To ensure continued compliance a 4-year inspection is already scheduled for April 2025 and email conformation is provided. **(Attachment H.2)**<br>Ongoing Monitoring: Maintenance will be responsible for maintaining a spreadsheet that lists all required inspections, due dates, vendors, completion dates and where the documentation is stored. In addition, these inspections will be scheduled in WorxHub, the maintenance workorder system, to ensure proper timing of all inspections. The facility will maintain proper documentation of all future inspections to ensure records are available for review. | |

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| | third fire damper location was also in HVAC ductwork which penetrated the attic smoke barrier wall next to the 1-hour fire resistance rated door above Aspen Commons on the other side of the atrium. The location of the third fire damper was accessed using the ladder to the attic in the room by Room 3225 in Aspen Commons. Based on interview at the time of the observations, the Health Center Technician agreed it could not be ensured the aforementioned three fire damper locations in the attic were inspected and tested within the most recent four year period.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | | |
| K 0911 SS=E Bldg. 01 | NFPA 101<br>Electrical Systems - Other<br>Electrical Systems - Other<br>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Chapter 6 (NFPA 99)<br>Based on observation and interview, the facility failed to ensure access and working space was maintained in 1 of over 2 electrical panel rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical | K 0911 | **K911 – Electrical Systems - Other**<br>Deficiency: This deficiency was cited due to three trash bins being placed against the wall below wall mounted electrical panels, within the working space of the room.<br>Corrective Action: The three trash bins were removed from below the | 10/01/2024 |

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| | equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A)(1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A) (1) which the minimum clear distance is 3 feet. Article 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. 110.26(A)(3) states the work space shall be clear and extend from the grade, floor, or platform to a height of 6 and 1/2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Mechanical Room inside the Heatherwood Commons Dining Room/Activities Room.<br><br>Findings include:<br><br>Based on observations with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during a tour of the facility from 1:20 p.m. to 4:10 p.m. on 08/14/24, three trash cans were placed up against the wall underneath the wall mounted electrical panels identified as "KXC Sect. 1" and "KXC Sect. 2" in the Mechanical Room inside the Heatherwood Commons Dining Room/Activities Room. The three trash cans were stored within the working space in front of the electrical panels | | electrical panels immediately.<br>Ongoing Monitoring: Maintenance will be responsible for conducting audits of all working spaces adjacent to electrical panels weekly for 4 weeks, and then monthly for 3 months thereafter, to ensure that no items are obstructing access to the panels. Any issues identified will be addressed immediately and staff will be re-educated on the importance of keeping these areas clear. **(Attachment J)**<br>All Maintenance Department personnel will be educated regarding the requirements for mechanical rooms.<br>Audits completed by the maintenance department will be reviewed by the Life Safety Committee during the next quarterly Life Safety Committee meeting, or until the Life Safety Committee determines substantial compliance has been achieved | |

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| | in the room. Based on interview at the time of the observations, the Health Center Technician agreed the aforementioned items were stored within the working space in front of the electrical panels in the room.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | | |
| K 0914 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Maintenance and Testing<br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. | | | |

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| | 6.3.4 (NFPA 99)<br>Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents.<br><br>Findings include:<br><br>Based on review of "Health Center Resident Rooms Electrical Receptacle Audit" documentation dated 03/23/22 with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during record review from 9:30 a.m. to 1:00 p.m. on | K 0914 | **K914 –Electrical Systems – Maintenance and Testing**<br>Deficiency: This deficiency was cited due to documentation showing testing of electrical receptacles in residents rooms within the last twelve month period could not be located, and therefore was not available for review.<br>Corrective Action: To ensure compliance, an inspection of all resident room electrical receptacles was completed on 8/29/24 to ensure that receptacles are functioning properly and meet safety standards. **(Attachment K)**<br>Ongoing Monitoring: Following the initial inspection, maintenance will be responsible to conduct quarterly spot audits of electrical receptacles in resident rooms for one year. Any issues identified will be addressed immediately. **(Attachment L)**<br>Audits completed by the maintenance department will be reviewed by the Life Safety Committee during the next quarterly Life Safety Committee meeting, or until the Life Safety Committee determines substantial compliance has been achieved. | 10/01/2024 |

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| | 08/14/24, electrical receptacle inspection and testing documentation for all resident sleeping rooms within the most recent twelve month period was not available for review. The 03/23/22 testing documentation was more than one year old. Based on interview at the time of record review, the Health Center Technician stated it takes quite a while to complete annual inspection and testing and agreed electrical receptacle inspection and testing documentation for all resident sleeping rooms for the most recent twelve month period was not available for review. Based on observations with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during a tour of the facility from 1:20 p.m. to 4:10 p.m. on 08/14/24, all resident sleeping rooms had non-hospital-grade receptacles installed in the rooms.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | | |
| K 0918 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. | | | |

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| | Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>1. Based on record review and interview, the facility failed to exercise 3 of 3 generators for 1 month of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer<br>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.<br>Section 8.4.2.3 states diesel-powered EPS | K 0918 | **K918 – Electrical Systems – Essential Electric System Maintenance and Testing**<br>Deficiency: This deficiency was cited due to (1) generator load testing from July 2024 for three generators not being available for review. (2) documentation from annual fuel quality testing for three generators within the most recent twelve-month period not being available for review. (3) documentation from emergency testing for 3 of 3 generators showing 4 continuous hours of load testing withing the last 36 | 10/01/2024 |

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| | installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Emergency Generator-30 Minute Monthly Test Log" documentation with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during record review from 9:30 a.m. to 1:00 p.m. on 08/14/24, load testing documentation for July 2024 was not available for review. Based on interview at the time of record review, the Health Center Technician stated the health care portion of the facility has three emergency generators, he performed monthly load testing during July 2024 for the three generators but agreed monthly load testing documentation for July 2024 was not available for review.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's three diesel fuel fired emergency generators. NFPA 99, Health | | months no being available for review.<br>Corrective Action: (1) The internal monthly generator exercise report for all three generators for July has been located and is provided **(Attachment M).** The generator exercise report for August is also provided to demonstrate compliance. **(Attachment M).** An audit will be conducted monthly for 6 months to ensure ongoing compliance. **(Attachment N)**<br>(2) The annual fuel quality test has been located and is provided **(Attachment O)**, completed by MacAllister on 6/18/24.<br>(3) The 36-month emergency generator testing for all three generators has been located and is provided **(Attachment P)**, including both a 2-hour load test and a 4-hour load test, completed by MacAllister on 6/7/24.<br>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 responsible for maintaining a spreadsheet that lists all annual and semi-annual inspections, due dates, vendors, completion dates and where the documentation is stored. In addition, these inspections will be scheduled in WorxHub, the maintenance workorder system, to ensure proper timing of all | |

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| | Care Facilities Code, 2012 Edition, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician from 9:30 a.m. to 1:00 p.m. on 08/14/24, documentation of an annual fuel quality test for the facility's three diesel fuel fired emergency generators within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Health Center Technician stated the health care portion of the facility has three diesel fuel fired emergency generators and agreed documentation of an annual fuel quality test for the three generators within the most recent twelve month period was not available for review.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b)<br><br>3. Based on record review and interview; the facility failed to document 36 month period | | inspections. The facility will maintain proper documentation of all future inspections to ensure records are available for review. | |

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|---|---|---|---|
| | 155167 | A. BUILDING 01<br>B. WING | 08/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WESTMINSTER VILLAGE NORTH | 11050 PRESBYTERIAN DR<br>INDIANAPOLIS, IN 46236 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | emergency generator testing for 3 of 3 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.1 states for a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. Section 8.4.9.5.2 states for a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Section 8.4.9.5.7 states where 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 loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician | | | |

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| | during record review from 9:30 a.m. to 1:00 p.m. on 08/14/24, thirty-six month period emergency generator testing for four continuous hours for the facility's three diesel fired emergency generators was not available for review. Based on interview at the time of record review, the Health Center Technician stated the health care portion of the facility has three diesel fuel fired emergency generators and agreed thirty-six month period emergency generator testing for four continuous hours for the facility's three diesel fired emergency generators was not available for review.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | | |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are | | | |

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| | used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors. | K 0920 | **K920 – Electrical Equipment – Power Cords and Extension Cords**<br>Deficiency: This deficiency was cited due to 2 of 2 extension cords, including power strips were used as a substitute for fixed wiring in resident rooms.<br>Corrective Action: The power strip in Juniper Room 3382 was removed and replaced immediately. Child safety plugs are being installed in all resident rooms, including Juniper Room 3380, where electrical receptacles are built into the base of lamps. Lamps with electrical receptacles in the base will be changed out over the coming years. Residents and families will be informed via email communication, as well as by our Admissions Coordinator at the time of admission, that power strips, multi-plug adapters, and extension cords cannot be used in place of fixed wiring in the resident's rooms.<br>Ongoing Monitoring: Audits will be conducted weekly for 4 weeks, and then monthly thereafter, to ensure that residents are not using power strips or other | 10/01/2024 |

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| | Findings include:<br><br>Based on observations with the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during a tour of the facility from 1:20 p.m. to 4:10 p.m. on 08/14/24, the following was noted:<br>a. a cell phone charging cable was plugged into a power strip placed on a night stand one foot from the resident bed in Room 3382 in Juniper Commons. The UL listing of the power strip could not be determined.<br>b. a wheel chair battery charger device was plugged into an electrical receptacle built into the lamp on a night stand one foot from the resident bed in Room 3380 in Juniper Commons. The UL listing of the receptacle in the lamp could not be determined.<br>Based on interview at the time of the observations, the Director of Campus Environment and the Health Center Technician agreed power strips were being used in the patient care vicinity for PCREE and non-PCREE and was also being used as a substitute for fixed wiring at the two aforementioned locations.<br><br>These findings were reviewed with the Executive Director, the Associate Executive Director, the Director of Campus Environment and the Health Center Technician during the exit conference.<br><br>3.1-19(b) | | unauthorized electrical devices. Maintenance will also conduct spot checks during routine rounds to ensure compliance with electrical safety standards. Any violations will be corrected immediately, and residents and staff will be re-educated on proper electrical safety practices.<br>**(Attachment Q)**<br>Audits completed by the maintenance department will be reviewed by the Life Safety Committee during the next quarterly Life Safety Committee meeting, or until the Life Safety Committee determines substantial compliance has been achieved. | |