PRINTED: 11/16/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDI	CAID SERVICES			OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389			(X3) DATE SURVEY COMPLETED 10/20/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR 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 accordance with 4 Survey Date: 10/2 Facility Number: Provider Number: 10 At this Emergency Westpark A Wate compliance with I Requirements for	20/22 000473 155389	E 0000	The following Plan of Correctic constitutes the facility's writter allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission and does not constitute an agreement with alleged deficiencies herein. The Plan Correction is submitted to meet the requirements established the state and federal regulation. The facility requests a desk review.	e of et by	
E 0041 SS=F Bldg	the survey, the cer Quality Review co The requirement a MET as evidenced 482.15(e), 483.7 Hospital CAH an §482.15(e) Cond (e) Emergency a The hospital must standby power s emergency plan this section and	ompleted on 10/25/22 at 42 CFR, Subpart 483.73 is NOT at by: 3(e), 485.625(e) d LTC Emergency Power dition for Participation: and standby power systems. Set implement emergency and systems based on the set forth in paragraph (a) of in the policies and set forth in paragraphs (b)(1)				

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

§483.73(e), §485.625(e)

TITLE (X6) DATE

Kesha LaGrone **HFA** 11/04/2022

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						ORM APPROVED MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD N TIBBS AVE		
WESTPA	WESTPARK A WATERS COMMUNITY		INDIA	NAPOLIS, IN 46222		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	(e) Emergency and The [LTC facility as implement emerge systems based or forth in paragraph §482.15(e)(1), §48 Emergency gener generator must be the location requirements and TIA 12-5, and Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built of structure or building 482.15(e)(2), §483 Emergency generation the eminspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §483 Emergency generation and LTC facilities] source to power end LTC facilities] source to power end the eminspection, testing requirements four Facilities Code, N Code.	and the CAH] must ency and standby power in the emergency plan set (a) of this section. 83.73(e)(1), §485.625(e)(1) eator location. The elocated in accordance with rements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) eator inspection and testing. H and LTC facility] must rergency power system ind in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) eator fuel. [Hospitals, CAHs is that maintain an onsite fuel emergency generators must in wit will keep emergency in personnel during the				

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§483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155389	B. WING		10/20/2022	
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEF	₹		I TIBBS AVE		
WESTPA	ARK A WATERS CO	OMMUNITY		NAPOLIS, IN 46222		
				,	T	
(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 APPROPRI DEFICIENCY)	IATE SSIII ZZ IISI	
TAG	†	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCIT	DATE	
	1	Director of the Office of the				
		in accordance with 5 U.S.C.				
	, ,	R part 51. You may obtain				
		the sources listed below.				
		a copy at the CMS				
		urce Center, 7500 Security				
		ore, MD or at the National				
		ords Administration				
		mation on the availability of				
		ARA, call 202-741-6030, or				
	go to:					
	http://www.archives.gov/federal_register/code					
	_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are					
		eference, CMS will publish a				
		Federal Register to				
	announce the cha	-				
	Batterymarch Par	Protection Association, 1				
	Quincy, MA 02169 1.617.770.3000.	e, www.mpa.org,				
		th Care Facilities Code,				
		ed August 11, 2011.				
		im amendment (TIA) 12-2 to				
	NFPA 99, issued					
		FPA 99, issued August 9,				
	2012.	1 7 7 00, 100 a 0 a 7 a gust 9,				
		FPA 99, issued March 7,				
	2013.					
		PA 99, issued August 1,				
	2013.	, · · · · · · · · · · · · · ·				
		FPA 99, issued March 3,				
	2014.	· ·				
		fe Safety Code, 2012				
	edition, issued Au	- · · · · · · · · · · · · · · · · · · ·				
		IFPA 101, issued August				
	11, 2011.					
		FPA 101, issued October				
	30, 2012.	· -				
		FPA 101, issued October				

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AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389			JILDING	ONSTRUCTION	(X3) DATE COMPL 10/20	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	REGULATORY OF 22, 2013. (xi) TIA 12-4 to NI 22, 2013. (xiii) NFPA 110, S Standby Power Sincluding TIAs to 2009. Based on record reginterview; the facility emergency powers maintenance requir Care Facilities Cod Code in accordance This deficient pract Findings include: Based on record regint Maintenance from 10/20/22, thirty-six generator testing do continuous hours for generator was not a interview at the time of Maintenance starpropane fired emergency within the mowas not available for observations with the during a tour of the p.m. on 10/20/22, the emergency generator testing the continuous with the p.m. on 10/20/22, the emergency generator testing the continuous with the p.m. on 10/20/22, the emergency generator testing the continuous with the p.m. on 10/20/22, the emergency generator testing the continuous with the p.m. on 10/20/22, the emergency generator testing the continuous with the p.m. on 10/20/22, the emergency generator testing the continuous with the p.m. on 10/20/22, the emergency generator testing the continuous with the p.m. on 10/20/22, the emergency generator testing the continuous hours for generator		EO	TAG	E041– It is the intent of the farto ensure to implement the emergency power system inspection, testing and maintenance requirements for in the Health Care Facilities Construction of the Health Care Time of the	cility und code, de in 73(e) IS ty six ous sults der ED: ff	
	nameplate rating fo rated at 20 kW. This finding was re	r the generator stated it was viewed with the Administrator			REOCCURRENCE: a. On _10/21/22 the Administrator in-serviced the Maintenance Supervisor/design	gnee	
	and the Director of Maintenance during the exit conference.				on the requirement that a thirt -six month period emergency	.y	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2022	
	ROVIDER OR SUPPLIE		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE NAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORI O			generator test for four continuations must be conducted on facilities emergency generator every three years to meet set standards. b. The Maintenance Supervisor/designee will ensurthirty -six month period emergency generator test for continuous hours is conducted every three years and documented in the life safety binder to meet standards. c. The Administrator will monitor adherence to the Emergency Preparedness Polymanual and validate the documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. At least annually to ensure compliance, the Administrator Maintenance Supervisor/desi will review the Emergency Preparedness Policy Manual make changes as necessary meet set standards. Those reviews will be documented a appropriate. The Administrator present the training results at Quality Assurance/ Performal Improvement (QA/PI) meeting Results and system compone will be reviewed by the QA/PI Committee with subsequent pof correction developed and implemented as deemed necessary to ensure compliant is maintained. This plan of correction	tous the r ure a four d ented ented et set dicy sure r and gnee and to us or will the noe g. ents blans

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/20/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(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) constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is11/25/22_	DATE		
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/20 Facility Number: 0 Provider Number: 100 At this Life Safety 0 Waters Community with Requirements Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa This one-story facil the original section (200) construction a was determined to b The facility is fully fire alarm system w corridors and in all The facility has smo fire alarm system in	00473 155389 290410 Code survey, Westpark A was found not in compliance	K 0000	The following Plan of Correctic constitutes the facility's writter allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission and does not constitute an agreement with alleged deficiencies herein. The Plan Correction is submitted to me the requirements established the state and federal regulation. The facility requests a desk review.	n to of et by		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/20/2022	
	PROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE NAPOLIS, IN 46222	
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0100 SS=E Bldg. 01	construction. The f had a census of 25 a All areas where the access were sprinkle detached storage sh sprinklered. Quality Review con NFPA 101 General Requirem General Requirem List in the REMAR Section 18.1 and that are not addre K-tags, but are de along with the app NFPA standard ciron Form CMS-256 1. Based on observation failed to ensure 1 of dining room would 4.6.12.3 requires exobvious to the publishall be either main deficient practice constaff and visitors in room. Findings include: Based on observation Maintenance during 12:00 p.m. to 1:15 properties of the control of the east dinition open position with a service of the control of the east dinition of the control of the co	residents have customary ered. The facility has two eds which were not enpleted on 10/25/22 ments - Other enerts - Other exts section any LSC 19.1 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included	K 0100	K100— It is the intent of the facto ensure corridor doors to the east dining room would self-cloper 4.6.12.3 and to ensure corridor sets would self-close and latch into the door frame per 4.6.12.3 to meet set standards 1. CORRECTIVE ACTIONS TAKEN: a. On _10/21/22_ the Maintenance Supervisor/desig made repairs to the door to the east dining room to ensure the door fully self closes and latch into the door frame to meet set standards. The Administrator verified the work on11/4/22_ b. On _10/21/22_ the	sility 11/25/2022 lose ridor d s. S nee e e e e e e e e e e e e e e e e e e
	latching hardware a	nd a self closing device but tch into the door frame when		Maintenance Supervisor/desig	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155389	B. W	B. WING			2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2					
\\/CCTD\					TIBBS AVE		
WESTPA	ARK A WATERS CO	DIVINIUNITY		INDIAN	IAPOLIS, IN 46222		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	tested to self close	multiple times. The door failed			west door in the corridor door	set	
		nd latch into the door frame			by Room 6 to ensure it fully se	elf	
	because the face of	the door on the door handle			closes and latches into the do	or	
	side kept hitting the	door frame neat the top of the			frame to meet set standards.	The	
	door. Based on inte	erview at the time of the			Administrator verified the work	on	
		irector of Maintenance agreed			11/4/22		
		the east dining room did not			2. ALL OTHERS WITH		
	self close and latch into the door frame when				POTENTIAL TO BE AFFECTE	D:	
	tested to self close multiple times.				a. All residents and all stat		
					and visitors have the potential	to	
	This finding was reviewed with the Administrator				be affected but none were. O	n	
	and the Director of Maintenance during the exit				10/21/22 the Maintenanc		
	conference.				Supervisor/designee inspected	d all	
					corridor doors throughout the		
	3.1-19(b)				facility and found no other neg	ative	
					findings.		
		ation and interview, the facility			3. MEASURES TO PREVE	NT	
		f 4 corridor door sets would			REOCCURRENCE:		
		into the door frame per			a. On10/21/22 th	е	
		12.3 requires existing life safety			Administrator in-serviced the		
		the public if not required by			Maintenance Supervisor/desig		
		either maintained or removed.			on the requirement that corrid		
	•	ice could affect over 10			doors must fully self- close and		
		visitors in the vicinity of the			latch into the frame to meet se	et	
	corridor door set by	Room 6.			standards.		
					b. Maintenance		
	Findings include:				Supervisor/designee will inspe		
					all corridor doors throughout the		
		ons with the Director of			facility monthly to ensure they		
		g a tour of the facility from			fully self-close and latch into the		
		p.m. on 10/20/22, the west door			frame as a part of the facility's		
		set by Room 6 was held in the			Preventive Maintenance Prog		
		with a magnetic hold open			and document those inspectio		
		e with fire alarm system			results as appropriate. If any		
		hardware and a self closing			issues are discovered, they wi	п ре	
		failed to self close and latch			addressed and resolved		
		when tested to close multiple			immediately. The Maintenand		
	_	he door kept hitting the door			Supervisor/designee will revie	W	
		ot fully self close and latch into			with the Administrator the		
	the door frame. Ba	sed on interview at the time of			inspection results.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>01</u>			COMPLETED	
		155389	B. W	ING		10/20/	2022	
N	DOLUBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				TIBBS AVE			
WESTPA	RK A WATERS CC	MMUNITY		INDIAN	IAPOLIS, IN 46222			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	· ·	e Director of Maintenance			c. The Administrator will			
	-	r in the door set would not			monitor adherence to the			
	fully self close and	latch into the door frame.			Preventative Maintenance			
	This finding was no	viewed with the Administrator			schedule and validate the			
	-	viewed with the Administrator Maintenance during the exit			Preventative Maintenance			
	conference.	iviannenance during the exit			documentation is in place. 4. MONITORING			
	comerence.				CORRECTIVE ACTION:			
	3.1-19(b)				a. The inspection results v	vill		
	J.1-17(0)	5.1-19(0)			be presented by the Maintena			
					Supervisor/designee to the	1100		
					Administrator monthly and the			
					Administrator will present the	'		
					inspection results at the month	nlv		
					Quality Assurance/Performan	-		
					Improvement (QA/PI) meeting			
					Inspection results and system			
					components will be reviewed l			
					the QA/PI Committee with			
					subsequent plans of correction	n		
					developed and implemented a	ıs		
					deemed necessary to ensure			
					compliance is maintained.			
					This plan of correction			
					constitutes our credible			
					allegation of compliance with	h		
					all regulatory requirements.			
					Our date of compliance is			
					11/25/22			
K 0222	NEDA 404							
SS=E	NFPA 101							
33-⊑ Bldg. 01	Egress Doors Egress Doors							
Diag. 01		d means of egress shall not						
	•	a latch or a lock that						
		f a tool or key from the						
	*	s using one of the following						
	special locking arr	-						
		OR SECURITY THREAT						
	LOCKING	JOIN DECOMMENT THINE ME						

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	ľ	JILDING	NSTRUCTION 01	(X3) DATE COMPI 10/20	LETED	
	F PROVIDER OR SUPPLIED PARK A WATERS CO		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDED TO THE APPROVIDED CROSS-REFERENCED CROSS-REFERENCED TO THE APPROVIDED CROSS-REFERENCED		I E RIATE	(X5) COMPLETION DATE	
	Where special loc clinical security no used, only one loc permitted on each be made for the riby: remote control locks or keys carrother such reliable staff at all times. 18.2.2.2.5.1, 18.2.19.2.2.2.6 SPECIAL NEEDS ARRANGEMENT Where special loc safety needs of the Clinical or Secare being met. In electrical locks the release upon loss building is protect automatic sprinkle space is protected detection system at an attended loc space); and both systems are arrar upon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies servir contents in building an approved, sup detection system automatic sprinkle 18.2.2.2.4, 19.2.2.	cking arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants of of locks; keying of all ried by staff at all times; or e means available to the except of the ex						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155389	B. W	ING		10/20	/2022
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	3			TIBBS AVE		
WESTP	ARK A WATERS CO	OMMUNITY			IAPOLIS, IN 46222		
VVLSIP	TI THE COMMONT			וואוטואוי	17 11 OLIO, IIN 40222		
(X4) ID	SUMMARY 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 APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	LOCKING ARRAI						
		d Egress Door assemblies					
		dance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2						
		BY EXIT ACCESS					
	LOCKING ARRAI						
	1	it access door locking in					
	accordance with 7.2.1.6.3 shall be permitted						1
	on door assemblies in buildings protected						
	throughout by an approved, supervised automatic fire detection system and an						
		•					
	approved, supervised automatic sprinkler						
	system.						
	18.2.2.2.4, 19.2.2		77. ^	222	Legge Him the state of the first	-1114	11/05/2022
		on and interview, the facility	K 0222		K222 - It is the intent of the fa	cility	11/25/2022
		means of egress through 1 of			to ensure means of egress		
	1	accessible for residents			through exits are readily		
		iagnosis requiring specialized			accessible for residents witho	ul a	1
		Doors within a required means be equipped with a latch or			clinical diagnosis requiring	n to	
	_	ne use of a tool or key from the			specialized security measures meet set standards.	5 10	
	_	otherwise permitted by LSC			1. CORRECTIVE ACTION	ıe	
		Door-locking arrangements			TAKEN:		
		n accordance with 19.2.2.2.5.2.			a. On10/21/22	2	
	_	ice could affect over 20			Certified Contractor/Maintena		
	_	visitors if needing to exit the			Supervisor replaced the keyp		
		ast Alcove exit door by Room			the exit door to the outside of		
	41.	and a second contract of the one			facility in the East Alcove by		
					Room 41 to meet set standard	ds.	
	Findings include:				The Administrator verified the		
					posting of the codes on		1
	Based on observati	ons with the Director of			11/4/22		
		g a tour of the facility from			2. ALL OTHERS WITH		
		p.m. on 10/20/22, the exit door to			POTENTIAL TO BE AFFECT	ED:	
	_	acility in the East Alcove by			a. All residents and all sta		
	Room 41 was marked as a facility exit with an exit				and visitors have the potentia		1
	sign and could be opened by entering a code into				be affected but none were. C		1
	_	r set. However, the keypad			10/21/22 the Mainter	nance	
	had no electrical power and was not operable.				Supervisor/designee inspecte		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/20/2022	
	PROVIDER OR SUPPLIE		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE JAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
IAU	The exit door could electrical power for interview at the time Director of Mainter not operable and a order. This finding was re-	In not be opened without or the keypad. Based on the of the observations, the mance stated the keypad was replacement keypad was on the eviewed with the Administrator of Maintenance during the exit	TAG .	doors to the means of egress ensure they were readily accessible for use and found other negative findings. 3. MEASURES TO PREV REOCCURRENCE: a. On 10/21/22 Administrator in-serviced the Maintenance Supervisor/desi on the requirement that doors must be readily accessible for to meet set standards. b. Maintenance Supervisor/designee will inspall means of egress througho facility weekly to ensure door readily accessible for use as part of the facility's Preventive Maintenance Program and document those inspection reas appropriate. If any issues discovered, they will be addreand resolved immediately. The Maintenance Supervisor/designial will review with the Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results of the Administrator monthly and the Administrator will present the inspection results at the month of the preventative of the Administrator will present the inspection results at the month of the preventative of the Administrator will present the inspection results at the month of the preventation is at the month of the preventation of the preventation is at the month of the preventation results at the month of the preventa	to no ENT _ the gnee s r use ect ut the s are a e essed ne gnee ator will ance

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AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIES			O1 ADDRESS, CITY, STATE, ZIP COD	COMPLETED 10/20/2022		
NAME OF PROVIDER OR SUPPLIES		STREET A	ADDRESS CITY STATE 7ID COD	10/20/2022		
NAME OF PROVIDER OR SUPPLIES			ADDRESS CITY STATE ZID COD			
			TIBBS AVE			
WESTPARK A WATERS CO	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		INDIANAPOLIS, IN 46222			
	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
i '	CY MUST BE PRECEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
K 0321 SS=E Bldg. 01 Hazardous Areas Hazardous areas barrier having 1-h (with 3/4 hour fire automatic fire exti accordance with 8 approved automa option is used, the from other spaces partitions and doc Doors shall be se automatic-closing nonrated or field-a do not exceed 48 the door. Describe the floor hazardous areas	- Enclosure - Enclosure - Enclosure are protected by a fire our fire resistance rating rated doors) or an nguishing system in 3.7.1 or 19.3.5.9. When the tic fire extinguishing system a areas shall be separated by smoke resisting rs in accordance with 8.4.		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed to the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is11/25/22	COMPLETION DATE De		
REMARKS. 19.3.2.1, 19.3.5.9 Area Separation	Automatic Sprinkler					

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STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		(X3) DATE SURVE	Y	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155389	B. WI	NG		10/20/2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER				TIBBS AVE		
WESTPA	ARK A WATERS CO	DMMUNITY			IAPOLIS, IN 46222		
(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 APPROPRIA	AIC	PLETION
TAG		R LSC IDENTIFYING INFORMATION	+-	TAG	DEFICIENCY)	D.	ATE
		-Fired Heater Rooms					
	, -	er than 100 square feet)	Ī				
	<u> </u>	nance, and Paint Shops	Ī				
		ooms (exceeding 64				1	
	gallons)	- D	Ī				
	e. Trash Collection						
	(exceeding 64 gal	•	Ī				
		orage Rooms/Spaces	Ī				
	(over 50 square fe	•	Ī				
	,	classified as Severe	Ī				
	Hazard - see K322	•	TZ 0	221	Mana in the state of the state of	oility:	5/2022
		ation and interview, the facility f over 8 hazardous areas such	K 0.	321	K321 – It is the intent of the fa	· I	25/2022
			Ī		to ensure hazardous areas su		
		than 100 square feet) were	Ī		as laundries are separated fro		
	_	er spaces by smoke resistant			other spaces by smoke resist		
	_	s. Doors shall be self closing			partitions and doors and ensu	ıre	
	1	g in accordance with 7.2.1.8.			hazardous areas such as		
	_	ice could affect over 20 visitors in the vicinity of the			combustible storage rooms of	ver	
	Laundry Room.	visitors in the vicility of the			50 square feet in size are	by	
	Laundry Kooiii.				separated from other spaces smoke resistant partitions and	-	
	Findings include:				doors to meet set standards.	1	
	i manigo metade.					16	
	Based on observation	ons with the Director of			1. CORRECTIVE ACTION TAKEN:	.	
		g a tour of the facility from	Ī		a. On 11/4/22 th	ne	
	_	p.m. on 10/20/22, a one half inch			Maintenance Supervisor/desi		
		as noted above the door handle			repaired the one- half inch in	955	
		or to the Laundry Room by the			diameter hole above the door		
		for the facility. Based on			handle for the corridor door to		
		e of the observations, the			Laundry Room by the souther		
	Director of Mainten		Ī		exit door with a 1 hour fire rat		
		cardous area corridor door	Ī		material to meet set standard		
	would not resist the		Ī		The Administrator verified the		
	1		Ī		on11/4/22		
	This finding was re-	viewed with the Administrator			b. The following will be		
		Maintenance during the exit	Ī		completed by 11/25/22t	he	
	conference.		Ī		Maintenance Supervisor/desi		
			Ī		installed a self- closure on the	-	
	3.1-19(b)		Ī		door to resident room 46 that		
					been converted to a storage r	oom	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155389	B. WI	NG	10/20/20		2022	
NAME OF T	DROLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF F	PROVIDER OR SUPPLIEF	t .			TIBBS AVE			
WESTPA	ARK A WATERS CO	DMMUNITY		INDIAN	IAPOLIS, IN 46222			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	2. Based on observation and interview, the facility failed to ensure 1 of over 8 hazardous areas such				for combustible boxes and			
					supplies to meet set standard			
		age rooms over 50 square feet			The Administrator verified the	work		
	_	ed from other spaces by smoke			on11/25/22			
	_	and doors. Doors shall be self			2. ALL OTHERS WITH			
		c closing in accordance with			POTENTIAL TO BE AFFECTI			
		ent practice could affect over 10			a. All residents and all state			
		visitors in the vicinity of			and visitors have the potential			
	Room 46.				be affected but none were. O	11		
	Findings include:				11/4/22 the	nnoo		
	rindings include.				Maintenance Supervisor/designspected all hazardous areas			
	Rosed on observative	ons with the Director of			holes and self-closing devices			
		g a tour of the facility from			_			
	_	o.m. on 10/20/22, resident			found no other negative findin 3. MEASURES TO PREVE			
		and been converted to a			REOCCURRENCE:	=IN I		
		mbustible boxes and supplies				·ho		
	_	m. The corridor door to Room			a. On10/21/22t Administrator in-serviced the	ii ie		
		ing or automatic closing.			Maintenance Supervisor/desig	nnoo		
	Based on interview	-			on the requirement that all	griee		
		irector of Maintenance agreed			hazardous areas remain free	of		
		the aforementioned hazardous			holes/penetrations and must h			
		osing or automatic closing.			self-closing devices to meet s			
	area was not sen en	only of automatic closing.			standards.	٠٠ <u> </u>		
	This finding was re	viewed with the Administrator			b. Maintenance			
	_	Maintenance during the exit			Supervisor/designee will inspe	ect		
	conference.				all hazardous area doors			
					throughout the facility monthly	, to		
	3.1-19(b)				ensure they remain free of			
					holes/penetrations and have s	self-		
					closing devices as a part of th			
					facility's Preventive Maintenar			
					Program and document those			
					inspection results as appropria			
					If any issues are discovered, t			
					will be addressed and resolve	-		
					immediately. The Maintenance			
					Supervisor/designee will revie			
					with the Administrator the			
					inspection results			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155389		A. BUILDING 01 COMPLET B. WING 10/20/2			
		10000	D. WI	_		10/20/	2 022
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
WESTPA	ARK A WATERS C	OMMUNITY			TIBBS AVE IAPOLIS, IN 46222		
	<u> </u>				I		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	ALLOGE, ITOM TO			1110	c. The Administrator will		D.T.L
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:	اانہ	
					a. The inspection results we be presented by the Maintena		
					Supervisor/designee to the	inicc	
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the mont	hly	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed	by	
					the QA/PI Committee with subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure	33	
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance wit	h	
					all regulatory requirements.		
					Our date of compliance is		
					11/25/22		
K 0345	NFPA 101						
SS=F	Fire Alarm System	m - Testing and					
Bldg. 01	Maintenance	3					
	Fire Alarm Syster	m - Testing and					
	Maintenance						
		m is tested and maintained					
		th an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
1	i national Fire Alai	m and Signaling Code.			1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155389	B. WING 10/20/2022			/2022		
		<u>I</u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIEF	₹			TIBBS AVE			
WESTDA	RK A WATERS CO	YTINI IMMC			IAPOLIS, IN 46222			
WESTPA	INN A WATERS CO	JIVIIVI OINI I I	_	INDIAN				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTI			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE	
	1	n acceptance, maintenance						
	and testing are readily available.							
		IFPA 70, NFPA 72						
		view, observation and	K 0	345	K345– It is the intent of the fac	cility	11/25/2022	
		ty failed to ensure 1 of 1 fire			to ensure alarm systems are			
		maintained in accordance with			maintained in accordance with			
		3 requires a fire alarm system to			9.6.1.3 to meet set standards.			
		and maintained in accordance			1. CORRECTIVE ACTION	S		
		ional Electrical Code and NFPA			TAKEN:			
	l '	larm Code. NFPA 72, 2010			` The following will be			
		.4.5 requires testing shall be			completed by 11/25/22	а		
	1 ^	dance with Table 14.4.5 Testing			licensed fire alarm			
		e 14.4.5 at 15(a) states duct			contractor/designee conducte			
		unctional tested annually.			functional testing and the sem			
		14.3.1 states that unless			annual visual inspection of the	9		
	_	by 14.3.2, visual inspections			duct detectors and retained			
	_	in accordance with the			documentation in the facilities	Life		
		14.3.1, or more often if required			Safety Binder to meet set			
	1 -	ving jurisdiction. Section			standards. The Administrator			
		cord of all inspections, testing			verified the work on			
		all be provided that includes			11/25/22			
		mation requested in Figure			1. ALL OTHERS WITH			
		cient practice could affect all			POTENTIAL TO BE AFFECTE			
	residents, staff and	VISITORS.			a. All residents and all stat			
	E. 1				and visitors have the potential	to		
	Findings include:				be affected but none were.	-		
	Dagad on	Stha fina alama avata			2. MEASURES TO PREVE	=N I		
		the fire alarm system			REOCCURRENCE:	_		
	_	or's "Fire Alarm System			a. On10/21/22 th	ie		
	_	entation dated 01/07/22 and			Administrator in-serviced the			
		Director of Maintenance during			Maintenance Supervisor/desig	-		
		10:00 a.m. to 12:00 p.m. on			on the requirement that alarm			
		il testing documentation and			systems must be maintained i	T1		
		inspection documentation for			accordance with 9.6.1.3 and	nual		
	1	uct detectors in the facility			functional testing and semi-an			
		ent twelve month period was			visual inspections on the duct			
		view. The 01/07/22 and			detectors must be performed to	ιο		
		system inspection and testing			meet set standards.			
		not include duct detectors.			b. Maintenance			
	Based on interview	at the time of record review,	1		Supervisor/designee will ensu	re		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS CO	MMUNITY	1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE IAPOLIS, IN 46222		
PREFIX (EACH DEFICIENC TAG REGULATORY OR	TATEMENT 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)	DATE	
the Director of Main alarm inspection doc recent twelve month review and agreed doctesting documentation month period was not on observations with during a tour of the figure. The p.m. on 10/20/22, on HVAC ductwork in exit door of the facil also noted in HVAC northwest nurse's sta	tenance stated additional fire cumentation for the most period was not available for uct detector inspection and on for the most recent twelve of available for review. Based in the Director of Maintenance facility from 12:00 p.m. to 1:15 are duct detector was noted in the closet by the southwest ity and one duct detector was	TAG	alarm systems are maintained functional testing and semi-ar visual inspections on the duct detectors are performed as a of the facility's Preventive Maintenance Program and document those inspection re as appropriate. If any issues discovered, they will be addre and resolved immediately. The Maintenance Supervisor/design will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 3. MONITORING CORRECTIVE ACTION: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	d and inual part sults are essed ne gnee after will ince hly ce d. hly ce d. hly ca d.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155389		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 10/20/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
				Our date of compliance is11/25/22			
K 0362 SS=E Bldg. 01	walls constructed resistance rating. compartments, paresist the transfer nonsprinklered bunderside of the five ceiling. Corridor with underside of ceiling permitted by Code Fixed fire window are in accordance sprinklered comparestrictions in area or frames. If the walls have a the rating terminate at the underside rating terminate at the underside rating terminate at the underside resistance rating terminate at the underside rating terminate at the underside resistance rating terminate at the underside rating terminate at the underside resistance rating terminate at the underside resistance rating terminate rating terminate resistance rating terminate rating terminate resistance resistance rating terminate rating terminate resistance resistance rating terminate	arated from use areas by with at least 1/2-hour fire In fully sprinklered smoke artitions are only required to of smoke. In aildings, walls extend to the loor or roof deck above the valls may terminate at the logs where specifically e. assemblies in corridor walls with Section 8.3, but in artments there are no a or fire resistance of glass of fire resistance rating, give if the walls in derside of the ceiling, give in REMARKS, describing the in the floor area.					
	Based on record revinterview; the facility walls in 1 of 5 smood constructed to resis 8.3.3.1 states fire waccompanying hard closing devices, and accordance with the Standard for Fire D	view, observation and ty failed to ensure corridor ke compartments were t the transfer of smoke. LSC indow assemblies and their ware, including all frames, chorage and sills shall be in e requirements of NFPA 80, oors and Other Openings 80, 2010 Edition, Section	K 0362	K362 – It is the intent of the facility to ensure corridor walls smoke compartments are constructed to resist the transfe of smoke to meet set standards 1. CORRECTIVE ACTIONS TAKEN: a. The following will be completed by 11/25/22 licensed contractor made the	er s. s		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/20/2022		
NAME OF I	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
					TIBBS AVE		
WESTPA	ARK A WATERS CO	DMMUNITY		INDIAN	IAPOLIS, IN 46222		
(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
		service counter fire doors, sills			necessary repairs to the two		
	_	s part of the fire door			rolling fire doors for the kitche		
	-	4.8.2.2 states sills shall be			the north wall of the east dinin	g	
		combustible materials. Section			room to ensure no gaps to me		
	_	ecial-purpose horizontally			set standards. The Administra	ator	
	_	r folding doors with frames			verified the repair on		
		h of 4 inches or less, the sill			11/25/22		
	•	l to the jamb depth. Section			2. ALL OTHERS WITH		
		en holes or breaks shall exist in			POTENTIAL TO BE AFFECTE		
		ne door or frame. This deficient			a. All residents and all stat		
	_	et over 20 residents, staff and			and visitors have the potential		
	visitors in the vicinity of the east dining room.				be affected but none were. The		
					facility only has two rolling dod		
	Findings include:				3. MEASURES TO PREVE	=N I	
	Događ on raviasy of	Etha rolling fire door inspection			REOCCURRENCE:		
	contractor's "Work	The rolling fire door inspection			a. On _10/21/22 the		
		ed 07/01/22 with the Director of			Administrator in-serviced the Maintenance Supervisor/design	nnoo	
		g record review from 10:00 a.m.			on the requirement that all fire		
		0/20/22, the kitchen has two			doors must remain free of gap		
		rith both windows needing a fire			resist the transfer of smoke to		
		which have no gaps when			meet set standards.		
		22 work order documentation			b. Maintenance		
		ws need a fire resistant			Supervisor/designee will inspe	ect	
		gaps in the bottom corners			all fire doors to ensure they re		
		ddition, review of "Invoice			free of gaps as a part of the		
		tation dated 07/05/22 also			facility's Preventive Maintenar	nce	
	stated "both window	ws need a fire resistant			Program and document those		
	threshold and have	gaps in the bottom corners			inspection results as appropria		
	when closed". Base	ed on interview at the time of			If any issues are discovered, t		
	record review, the I	Director of Maintenance stated			will be addressed and resolve	d	
	they don't use the n	nain roll down door that much,			immediately. The Maintenand	е	
	the inspection contr	ractor has not been back to the			Supervisor/designee will revie	w	
	facility since the 07	7/01/22 inspection and stated			with the Administrator the		
		ler. Based on observations			inspection results.		
		f Maintenance during a tour of			c. The Administrator will		
		:00 p.m. to 1:15 p.m. on 10/20/22,			monitor adherence to the		
	_	n was open to the corridor.			Preventative Maintenance		
		ors for the kitchen are in the			schedule and validate the		
	north wall of the ea	st dining room. The main roll			Preventative Maintenance		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 10/20/2022	
	PROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE NAPOLIS, IN 46222	
(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
	door was in the fully lunchtime. After lu closed position and corners of both rollifor the doors when closed position. Bathe observations, the agreed both rolling corners of the doors fully closed position. This finding was revenue.	y open position during nch, the door was in the fully gaps were noted in the ng doors near the bottom sill each door was in the fully sed on interview at the time of e Director of Maintenance fire doors had gaps in the when each door was in the		documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results were presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the mont Quality Assurance/Performan Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance wit all regulatory requirements. Our date of compliance is 11/25/22	hlly ce J. by
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in g fire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in g flammable or rials have positive latching			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	a. building <u>01</u>		
		155389	B. WING	B. WING		
			CERTE	ADDRESS CITY STATE TIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
\\\\ESTD/	ARK A WATERS C			NAPOLIS, IN 46222		
WESTER	ARK A WATERS C	OWNING INTERPRETATION OF THE PROPERTY OF THE P	INDIAN	NAPOLIS, IN 40222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
	hardware. Roller	latches are prohibited by				
	CMS regulation.	These requirements do not				
	apply to auxiliary	spaces that do not contain				
		nbustible material.				
	Clearance between	en bottom of door and floor				
	covering is not ex	ceeding 1 inch. Powered				
	_	with 7.2.1.9 are permissible				
		device capable of keeping				
	l .	when a force of 5 lbf is				
		no impediment to the				
		ors. Hold open devices that				
	1 -	door is pushed or pulled are				
		ted protective plates of				
	_ ·	are permitted. Dutch doors				
	_	.6 are permitted. Door				
	_	abeled and made of steel or				
		compliance with 8.3,				
	unless the smoke	-				
		d fire window assemblies are				
	1 '	n sprinklered compartments				
	1 · · · · · · · · · · · · · · · · · · ·	rictions in area or fire				
		ss or frames in window				
	assemblies.	ss of frames in window				
	assemblies.					
	10 2 6 2 42 CED	Parts 403, 418, 460, 482,				
	483, and 485	. Faits 403, 410, 400, 402,				
		KS details of doors such as				
		ings, automatics closing				
	devices, etc.	ion and intervious the facility	17 02 62	Maca It is the intent of the	11/05/2022	
		ion and interview, the facility of over 40 corridor doors had no	K 0363	K363 – It is the intent of the	11/25/2022	
		sing and latching into the door		facility to ensure corridor door		
	_	-		have no impediment to closing	·	
		esist the passage of smoke.		latching into the door frame as	ıu	
	_	tice could affect over 20		would resist the passage of		
	residents, staff and	VISILOTS.		smoke to meet set standards.		
	Pindings 1 1 1			1. CORRECTIVE ACTION	>	
	Findings include:			TAKEN:		
	n 1 1	' '4 4 D' ' C		a. On10/21/221		
		ions with the Director of		Maintenance Supervisor/design	•	
	Maintenance durin	g the initial walk through of the		removed the red chair from th	е	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		A. BUILDING B. WING	01	COMPLETED 10/20/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(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		
	facility from 9:30 a. corridor door to the nurse's station was pposition with a red of 12:18 p.m. on 10/20 Breakroom was still position with the red observations with the during a tour of the p.m. on 10/20/22, the a. a wedge was place corridor door to the office by Room 10 to open position. b. a one half inch in above the door hand Janitor's Closet by the c. a one half inch in above the door hand Laundry Room by the facility. Based on interview observations, the Difference and would not this finding was revenue.	m. to 9:45 a.m. on 10/20/22, the Breakroom by the northwest propped in the fully open chair. Based on observation at 1/22, the corridor door to the propped in the fully open dichair. Based on the Director of Maintenance facility from 12:00 p.m. to 1:15 the following was noted: the open the door in the fully diameter hole was noted the Nourishment Pantry. The diameter hole was noted the for the corridor door to the the southeast exit door for the corridor door to the the southeast exit door for the corridor door to the the southeast exit door for the corridor fo		corridor door to the breakroor the northwest nurse's station A) removed the wedge on the under the corridor door to the scheduler/medical records off by room 10, B) repaired the rinch in diameter hole above the door handle for the corridor do the Janitor's closet by the nourishment pantry with a 1 h fire rated material and C) repathe half inch in diameter hold noted above the door handle the corridor door to the laundroom by the southeast exit do with a 1 hour fire rated materimeet set standards. The Administrator verified the wor11/4/22 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potentia be affected but none were. The Maintenance Supervisor/designing spected all corridor doors for impediments to closing and frholes and found no other neg findings. 3. MEASURES TO PREVINGECURRENCE: a. On10/21/22 Administrator in-serviced the Maintenance Supervisor/designand all staff on the requirement that corridor doors may not half impediments to closing and maintenance standards. b. Maintenance	m by and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155389 B. WING			10/20/	/2022	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			TIBBS AVE		
WESTPA	ARK A WATERS C	OMMUNITY			IAPOLIS, IN 46222		
WEGII7		OWN ON THE		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Supervisor/designee will inspe		
					all corridor doors throughout the		
					facility monthly to ensure there		
					no impediments to closing and		
					they remain free of holes as a	part	
					of the facility's Preventive		
					Maintenance Program and		
					document those inspection re-		
					as appropriate. If any issues		
					discovered, they will be addre		
					and resolved immediately. Th		
					Maintenance Supervisor/desig	-	
					will review with the Administra	itor	
					the inspection results.		
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4. MONITORING		
					CORRECTIVE ACTION:	iII	
					a. The inspection results v		
					be presented by the Maintena Supervisor/designee to the	iic c	
					Administrator monthly and the	1	
					Administrator will present the		
					inspection results at the month	nlv	
					Quality Assurance/Performan	-	
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed		
					the QA/PI Committee with		
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE C A. BUILDING B. WING	onstruction (x 01	3) DATE SURVEY COMPLETED 10/20/2022
	PROVIDER OR SUPPLIEF		1316 N	ADDRESS, CITY, STATE, ZIP COD N TIBBS AVE NAPOLIS, IN 46222	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				all regulatory requirements. Our date of compliance is11/25/22	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be patrium wall. Smoke in duct penetration systems where are is installed for smote to the smoke barriers and to the smoke barriers and to the smoke barriers was resistance rating of 19.3.7.3, 8.6.7.1(1) Describe any med system in REMAF Based on observation failed to ensure ope smoke barriers was resistance rating of 19.3.7.3 refers to Sepenetrations for cast similar items that phasembly constructed through the ceiling barrier shall be protected as made for the assembly constructed through the requirement of the assembly constructed through the resistance of the assembly constructed through the requirement of the assembly constructed through the resistance of the assembly	nall be constructed to a tance rating per 8.5. Smoke termitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system toke compartments adjacent tier.	K 0372	K372 -It is the intent of the facilit to ensure openings through ceili smoke barriers are protected to maintain the fire resistance ratin of the smoke barrier to meet set standards. 1. CORRECTIVE ACTIONS TAKEN: a. On11/4/22 the Maintenance Supervisor/designer repaired the hole around a ceilin mounted sprinkler in the closet be the Breakroom by the northwest nurse's station with a one- hour fire rated material to meet set standards. The Administrator verified the repair on11/4/22	g g ee g

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/20/2022		
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222					
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	ON (X5) DBE COMPLETION DATE		
	nurse's station. Findings include: Based on observation Maintenance during 12:00 p.m. to 1:15 diameter hole around was noted in the clonorthwest nurse's stabove. Based on in observations, the During the aforementioned ensure the ceiling station maintain the fire resident. This finding was residued:	ons with the Director of g a tour of the facility from p.m. on 10/20/22, a two inch in a ceiling mounted sprinkler oset by the Breakroom by the tation and exposed the attic atterview at the time of the irector of Maintenance agreed hole in the ceiling did not moke barrier was protected to sistance rating of the smoke eviewed with the Administrator Maintenance during the exit		2. ALL OTHERS WITH POTENTIAL TO BE AFFE a. All residents and all and visitors have the poter be affected but none were10/21/22 the Maintenance Supervisor/de inspected all smoke barrier & ceilings throughout the fa for penetrations and found negative findings. 3. MEASURES TO PRI REOCCURRENCE: a. On 10/21/22 Administrator in-serviced the Maintenance Supervisor/de on the requirement that sm barrier walls & ceilings must free of penetrations and vomeet set standards. b. Maintenance Supervisor/designee will in all smoke barrier walls & ceilings must free of penetrations and voids as a the facility's Preventive Maintenance Program and document those inspection as appropriate. If any issued discovered, they will be ad and resolved immediately. Maintenance Supervisor/de will review with the Administ the inspection results. c. The Administrator with monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	CTED: staff hitial to On esignee r walls acility no other EVENT _ the he esignee hoke st be bids to spect eillings thly for a part of n results ues are dressed The esignee strator		

	OF CORRECTION	IDENTIFICATION NUMBER 155389	A. BUILDING B. WING	01	COMPLETED 10/20/2022
	ROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP COD TIBBS AVE IAPOLIS, IN 46222	
(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
				4. MONITORING CORRECTIVE ACTION: a. The inspection results was be presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed at the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is11/25/22	nity ce . by nis
K 0761 SS=E Bldg. 01					
	interview; the facilitinspection and testin were completed in a Communicating operequired by 19.1.1.4 corridors and shall be self-closing fire doc 8.3.) LSC 8.3.3.1 Oprotection rating by protected by approve	review, observation and by failed to ensure annual and of all fire door assemblies accordance of LSC 19.1.1.4.1.1. Enings in dividing fire barriers and shall be permitted only in the protected by approved ar assemblies. (See also Section penings required to have a fire Table 8.3.4.2 shall be ed, listed, labeled fire door window assemblies and their	K 0761	K761 – It is the intent of the facility to ensure annual insperand testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1 and to ensure proper operatio maintained for rolling steel fire doors in accordance with NFP 80 to meet set standards. 1. CORRECTIVE ACTION TAKEN: a. On11/4/22	n is

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY		1316 1	ADDRESS, CITY, STATE, ZIP COD N TIBBS AVE NAPOLIS, IN 46222			
(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)	ATE	(X5) COMPLETION DATE
	accompanying hard closing devices, and accordance with the Standard for Fire D Protectives, except Code. NFPA 80 5.2 shall be inspected a annually, and a wrishall be signed and AHJ. NFPA 80, 5.2 fire door and windoperformed by indivunderstanding of the type of door between the type of door of following items shall the type of door, frame noncombustible through the door, frame noncombustible through the door combustible through the door clearances listed in 4.8.4 and 6 (6) The self-closing the active door comfrom the full open to the type of type of the type of	ware, including all frames, chorage, and sills in a requirements of NFPA 80, coors and Other Opening as otherwise specified in this 2.1 states fire door assemblies and tested not less than a tten record of the inspection kept for inspection by the 2.3.1 states functional testing of the inspection by the 3.3.1 states functional testing of the assemblies shall be iduals with knowledge and the operating components of the ing subject to testing. NFPA are door assemblies shall be from both sides to assess the from both sides to assess the from the idle be verified: To breaks exist in surfaces of the ingential states and glazing beads are sellight frames, and glazing beads are sellight frames, and glazing beads are secured, aligned, are with no visible signs of the signs of the ingential states are signs of the signs of the signs of the signs of the ingential states are signs of the signs of th		Maintenance Supervisor/design conducted the annual inspect of the fire door assemblies for oxygen storage and transfillin room and documented those inspection results on the Annual Door Inspections log to meet standards. The Administrator verified the inspections and documentation on11/4/22 b. The following will be completed by 11/25/22 licensed contractor/Maintenar Supervisor made the necessare pairs to the serving window door to ensure it operates correctly with activation of the alarm meet set standards. The Administrator verified the inspections and documentation11/25/22 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. 3. MEASURES TO PREVIOUS REOCCURRENCE: a. On11/4/22 Administrator/corporate Proper Manager inserviced the Maintenance Supervisor/design on the requirement that annual testing & inspections of fire radoors including the oxygen	gnee ion r the g ual set the nce ary roll efire ne on on ED: ff I to ENT _ the erty gnee al uted	
	closes before the ac	tive leaf.	1	storage and transfilling room	must	

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(8) Latching hardware operates and secures the

(9) Auxiliary hardware items that interfere or

door when it is in the closed position.

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be conducted to ensure proper

operation and documented on the

Annual Door Inspections log and

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> CO			COMPL	ETED
		155389	B. WING		10/20/2022		
NAME OF I	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP COD		
=					TIBBS AVE		
WESTPA	RK A WATERS CC	DMMUNITY		INDIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(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 APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	prohibit operation a	re not installed on the door or			maintained at the facility to me	et	
	frame.				set standards.		
	(10) No field modif	ications to the door assembly			b. Maintenance		
	have been performe	d that void the label.			Supervisor/designee will cond	uct	
	(11) Gasketing and	edge seals, where required, are			the annual door inspections to		
	inspected to verify t	heir presence and integrity.			ensure proper operation and		
	This deficient pract	ice could affect over 20			document the inspection resul	ts	
	residents, staff and	visitors in the vicinity of the			on the Annual Door Inspection		
	oxygen storage rooi	n by the northeast nurse's			as a part of the facility's Preve	-	
	station.				Maintenance Program and		
					document those inspection res	sults	
	Findings include:				as appropriate. If any issues		
				discovered, they will be addressed			
	Based on review of	"Annual Inspection of	and resolved immediately. The				
	Swinging Fire Door	Assemblies" documentation	Maintenance Supervisor/designee				
		the Director of Maintenance	will review with the Administrator				
		w from 10:00 a.m. to 12:00 p.m.	the inspection results.				
	_	inspection documentation of			c. The Administrator will		
		s in the facility within the most			monitor adherence to the		
		n period did not include doors			Preventative Maintenance		
		ge and transfilling room.			schedule and validate the		
		at the time of record review,		Preventative Maintenance			
	the Director of Main	ntenance was unsure if the	documentation is in place.				
	05/17/22 fire door is	nspection documentation	4. MONITORING				
		xygen storage and transfilling			CORRECTIVE ACTION:		
		dditional fire door inspection			a. The inspection results w	/ill	
		he most recent twelve month		be presented by the Maintenance			
	period was not avail	lable for review. Based on			Supervisor/designee to the		
	_	ne Director of Maintenance			Administrator monthly and the		
	during a tour of the	facility from 12:00 p.m. to 1:15			Administrator will present the		
		ne corridor door to the oxygen			inspection results at the month	nly	
	_	ing room by the northeast			Quality Assurance/Performand	-	
	_	a fire-rated door with a 1-hour			Improvement (QA/PI) meeting		
	fire resistance rating	g label affixed to the hinge side			Inspection results and system		
		quid oxygen containers and			components will be reviewed by	ру	
		ygen cylinders were stored in			the QA/PI Committee with	-	
	the room.				subsequent plans of correction	า	
					developed and implemented a		
	This finding was re-	viewed with the Administrator			deemed necessary to ensure		

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and the Director of Maintenance during the exit

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compliance is maintained.

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	JILDING	onstruction 01	(X3) DATE COMPL 10/20/	ETED	
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222					
(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	regulatory of conference. 3.1-19(b) 2. Based on record interview; the facili operation was main fire doors in accord requires any device condition, arrangen other feature is required provision of this Consystem, condition, a protection, or other maintained unless the maintenance. NFP Standard for Fire Directives, Section automatic-closing devery rolling steel doors activation or release Section 11.4.2.2.1 selection 11.4.2.2.1 selection until has been reset. This affect over 20 residivicinity of the east of Findings include: Based on review of contractor's "Work documentation date	review, observation and ty failed to ensure proper tained for 1 of 2 rolling steel ance with NFPA 80. LSC 4.5.8, equipment, system, nent, level of protection, or any nired for compliance with the ode, such device, equipment, arrangement, level of feature shall thereafter be the Code exempts such A 80, 2010 Edition, the coors and Other Opening a 11.4.1.1 requires an elevice shall be installed on door. Section 11.4.1.2 states shall close automatically upon the of a fusible link or detector. States after the automatic the door shall remain in the 1 the automatic-closing device as deficient practice could ents, staff and visitors in the dining room.		This plan of correction constitutes our credible allegation of compliance wi all regulatory requirements Our date of compliance is11/25/22	th		
	to 12:00 p.m. on 10 rolling fire doors. documentation state inspection. The dis	y/20/22, the kitchen has two Γhe 07/01/22 work order ed "Performed annual roll door h window operated correctly dow did not drop with the fire					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		JILDING	nstruction 01	(X3) DATE COMPL 10/20/	ETED	
	PROVIDER OR SUPPLIER		1316 N	DDRESS, CITY, STATE, ZIP COD TIBBS AVE APOLIS, IN 46222		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	alarm". In addition documentation date "Performed annual window operated or window did not dro on interview at the Director of Mainter main roll down doo contractor has not be the 07/01/22 inspec on order. Based on Director of Mainter facility from 12:00 east dining room warolling fire doors fo wall of the east dini This finding was reand the Director of conference. 3.1-19(b)	RESC IDENTIFYING INFORMATION , review of "Invoice #i95977" d 07/05/22 also stated roll door inspection. The dish orrectly but the serving p with the fire alarm". Based time of record review, the nance stated they don't use the or that much, the inspection neen back to the facility since tion and stated parts may be observations with the nance during a tour of the p.m. to 1:15 p.m. on 10/20/22, the as open to the corridor. Both or the kitchen are in the north or groom. viewed with the Administrator Maintenance during the exit	TAG	DEFICIENCY)		DATE
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pro- annually confirm to safety and critical and testing of the switches are perfor NFPA 110. Generator sets are exercised under lo	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power inted equipment is capable on the within 10 seconds. If the in is not met during the pocess shall be provided to his capability for the life branches. Maintenance generator and transfer formed in accordance with the inspected weekly, and 30 minutes 12 times a intervals, and exercised				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/20/2022		
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY		1316 N	ADDRESS, CITY, STATE, ZIP COD TIBBS AVE IAPOLIS, IN 46222		
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Scheduled test un a complete simula automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with Noricuit breakers are program for period components is estimated and circuits are manufacturer requof maintenance are and readily available and circuits are mand separate from Minimizing the power consideration for moderation for	ual transfer of all EES inducted by competent nance and testing of stored rces (Type 3 EES) are in IFPA 111. Main and feeder is inspected annually, and a dically exercising the rablished according to uirements. Written records ind testing are maintained ble. EES electrical panels arked, readily identifiable, in normal power circuits. Is sibility of damage of the source is a design new installations. (NFPA 99), NFPA 110,	K 0918	K918 – It is the intent of the facility to ensure to document month period emergency generator testing for emerger generators in accordance with NFPA 99 & NFPA 110 to mee standards. 1. CORRECTIVE ACTION TAKEN: a. The following will be completed by 11/25/22_the Licensed generator contractor/Maintenance Super conducted the thirty six month period emergency generator for four continuous hours and documented the results in the facilities Life Safety Binder to	rvisor

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155389	B. WING 10/20/2022			/2022	
			I	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			TIBBS AVE		
WESTDA	RK A WATERS CO	MMI INITY			APOLIS, IN 46222		
VVLSIFA	THE PROPERTY OF	ZIVIIVIOINI I	1	וואוטואוו	, ii OLIO, II i 4 0222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY 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
		ed in 8.4.9.5.1, 8.4.9.5.2, or			meet set standards.		
		3.4.9.5.3 states for spark-ignited			2. ALL OTHERS WITH		
	_	be the available EPSS load.			POTENTIAL TO BE AFFECTE		
	1	ice could affect all residents,			a. All residents and all stat		
	staff and visitors.				and visitors have the potential	to	
	F. 1				be affected but none were.		
	Findings include:				3. MEASURES TO PREVE	:NT	
	D 1 1	' 'd d D' ' e			REOCCURRENCE:		
		view with the Director of			a. On	J	
		10:00 a.m. to 12:00 p.m. on				he	
		month period emergency			Administrator in-serviced the		
		ocumentation for four			Maintenance Supervisor/desig	•	
		or the facility's emergency		on the requirement that a thirty		У	
	_	vailable for review. Based on			-six month period emergency		
		e of record review, the Director			generator test for four continu	ous	
		ted the facility has one			hours is required to meet set		
		gency generator and agreed			standards.		
		vailable load testing for four			b. The Maintenance		
		ost recent three year period or review. Based on			Supervisor/designee will ensu	re a	
		he Director of Maintenance			thirty- six month period	£	
		facility from 12:00 p.m. to 1:15			emergency generator test for		
		he facility has one propane fired			continuous hours is conducted every three years and docume		
	l -	or located outside the building			in the life safety binder to mee		
		door set. Manufacturer's			standards.	:1 501	
		r the generator stated it was			c. The Administrator will		
	rated at 20 kW.	i die generator stated it was			monitor adherence to the		
	Tated at 20 KW.				Preventative Maintenance		
	This finding was re	viewed with the Administrator			schedule and validate the		
		Maintenance during the exit			Preventative Maintenance		
	conference.	<i>6</i>			documentation is in place.		
					4. MONITORING		
	3.1-19(b)				CORRECTIVE ACTION:		
					a. The inspection results w	vill	
					be presented by the Maintena		
					Supervisor/designee to the		
					Administrator monthly and the		
					Administrator will present the		
					inspection results at the month	nlv	
					Quality Assurance/Performan	-	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	ì í	JILDING	onstruction 01	(X3) DATE COMPL 10/20/	ETED
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(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)	TE	(X5) COMPLETION DATE
					Improvement (QA/PI) meeting Inspection results and system components will be reviewed If the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is11/25/22	oy n as	

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