STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155135	A. BUILDING -- B. WING	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN 47421

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/25/24 Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600 At this Emergency Preparedness survey, Westview Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 95 certified beds. At the time of the survey, the census was 77. Quality Review completed on 01/26/24	E 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
K 0000 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). Survey Date: 01/25/24 Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600 At this Life Safety Code survey, Westview	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Randy Padgett	Executive Director	02/01/2024

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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	Nursing and Rehabilitation Center 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, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident sleeping rooms in Cottage Hall are provided with smoke detectors hard wired to the fire alarm system. Battery operated smoke alarms are installed in all other resident sleeping rooms. The facility has a capacity of 95 and had a census of 77 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has one detached storage building which was not sprinklered. Quality Review completed on 01/26/24			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent			

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	to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 10 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 01/25/24 at 2:10 p.m. during a tour of the facility with the Environmental Services Supervisor, Maintenance Supervisor and Field Supervisor, the following unsealed penetrations were noted: a. The smoke barrier wall above the smoke barrier doors near room 23, two different bundles of cables through the wall had a half inch gaps around the cables. Each penetration through the smoke barrier wall were not properly filled with fire stop material. Based on interview at the time of observations, the Environmental Services Supervisor said she was not aware of the open penetrations through the smoke barrier wall, and would have them filled with a proper fire stop material as soon as possible. This finding was reviewed with the Environmental Services Supervisor, Maintenance Supervisor and Field Supervisor at the exit conference. 3.1-19(b)	K 0372	1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On January 26, 2024, Maintenance supervisor filled/sealed gaps area around cables with proper fire stop material. 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Residents, staff, and/or visitors in the vicinity of barrier doors by room 23 have the potential to be affected by the alleged deficient practice. The Maintenance Director checked all smoke barrier walls to verify smoke barrier walls with open penetrations through the smoke barrier wall was filled/seal with proper fire stop material. 3. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?** The Executive Director conducted an in-service with Environmental Director and Maintenance Director of proper inspection of smoke barrier walls.	01/31/2024

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			4. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The Maintenance Director/designee will monitor smoke barrier walls weekly times 4, monthly times 4, and quarterly times 2. Any concerns/issues will be brought to the QAPI committee for review.	