STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155167	A. BUILDING -- B. WING	04/11/2023

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/11/23 Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600 At this Emergency Preparedness survey, Westminster Village North was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 148 certified beds. At the time of the survey, the census was 123. Quality Review completed on 04/17/23	E 0000	April 28, 2023 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID HGRJ21 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during our Life Safety Code Recertification and State Licensure Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Shannon Harris Administrator	
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	K 0000	April 28, 2023 Ms. Brenda Buroker	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Harris		04/28/2023

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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	483.90(a). Survey Dates: 04/11/23 Facility Number: 000084 Provider Number: 155167 AIM Number: 100284600 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, Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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		Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID HGRJ21 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during our Life Safety Code Recertification and State Licensure Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Shannon Harris Administrator	

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	148 and had a census of 123 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 04/17/23			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 7 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately	K 0211	K211 1 – Upon identification of totes stored in the hallway, they were immediately moved to the appropriate location. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Activities Director will in-service staff on appropriate places to storage activity boxes. 4 – The Activity Director, or designee, will audit Cedar Commons weekly for 4 weeks to make sure there are no totes	04/28/2023

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	16 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Director of Campus Operations (D.C.O.) and the Administrator-in-training (A.I.T) during a tour of the facility on 04/11/23 at 2:45 p.m., there were six 10-gallon plastic totes stored and unattended in the corridor directly across from the Cedar nurses' station. Based on interview with the D,C,O, at the time of the observation, he acknowledged the items in the corridor and added that they belonged to the Activities Department and he was sure they would be taken care of or removed by the end of the day. This finding was reviewed with the D.O.C. and the A.I.T during the exit conference on 04/11/23 at 3:15 p.m. 3.1-19(b)		sitting on the floor in any hallways. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of three (3) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/28/2023.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously maintained in proper operating condition. NFPA 72, National Fire Alarm and	K 0345	K345 1 – Upon notification from the surveyor, AADCO (fire panel	04/24/2023

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	Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations made with the Director of Campus Operations (D.C.O.) and the Administrator-in-training (A.I.T) during a tour of the facility on 04/11/23, the following was noted: a. the main fire alarm panel at the Heatherwood nurse's station read the date as December 14th 2014 and the time of day as 14:52 at 2:23 p.m. b. the remote fire alarm panel at the Heatherwood main entrance vestibule read the date as December 14th 2014 and time of day as 14:42 at 3:11 p.m. c. the remote fire alarm panel at the Willow Commons nurse's station read the date as December 14th 2014 and the time of day as 13:40 p.m. at 1:11 p.m. d. the remote fire alarm panel at the Aspen nurse's station read the date as December 14th 2014 and the time of day as 12:19 p.m. at 1:48 p.m. e. the remote fire alarm panel at the Aspen north nurse's station read the date as December 14th 2014 and time of day as 12:33 p.m. at 2:02 p.m. f. the remote fire alarm panel at the Juniper Commons vestibule read the date as December 14th 2014 and the time of day as 12:52 p.m. at 2:21 p.m. g. the remote fire alarm panel at the Cedar Commons nurse's station read the date as December 14th 2014 and the time of day as 13:28 at 1:57 p.m. h. the remote fire alarm panel at the Cedar Commons vestibule read the date as December 14th 2014 and the time of day as 13:30 at 2:59 p.m. i. the remote fire alarm panel at the Cedar		service provider) was contacted to adjust the date and time on the panels. The fire panels were adjusted on 4/12/2023. 2 – The facility has determined that no residents were affected. 3 – The Director of Campus environment will conduct a training with maintenance staff regarding monitoring the date/time periodically to make sure it's correct. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of two (2) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/24/2023.	

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	Commons nurse's station by Activities read the date as December 14th 2014 and the time of day as 13:39 at 3:08 p.m. Based on interview at the time of the observations, the D.O.C. agreed each of the fire alarm panels did not display the correct time of day at the time of the observation. This finding was reviewed with the D.O.C. and the A.I.T during the exit conference on 04/11/23 at 3:15 p.m. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 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 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			

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	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. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 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 1 Physical Therapy corridor door set was provided with a means suitable for keeping the door closed, had no impediment to closing, latching, and would resist the passage of smoke. This deficient practice could affect as many as 8 residents, 4 staff and 1 visitor in the vicinity of Physical Therapy. Findings include: Based on observations made with the Director of Campus Operations (D.C.O.) and the Administrator-in-training (A.I.T) during a tour of the facility on 04/11/23 at 2:00 p.m., the corridor door to the Mary Newill Therapy Center had a flip down door stop attached to the entry / exit door. This doorstop was down and not allowing the self-closing device attached to the door to function as intended. Based on an interview at the time of the observation, the D.O.C. advised that he was unaware the doorstop was mounted on the door and would have it removed immediately.	K 0363	K363 1 – Upon notification from the surveyor, the Mary Newill Center (Therapy Dept) had a flip down door stop. The door stop was removed from the door immediately. 2 – The facility has determined that resident who use the therapy department have the potential to be affected. 3 – The Director of Campus Environment and Administrator will continue on-going education to staff regarding door stops and they are prohibited from being used in our building. 4 – The DCE or designee will conduct random weekly audits for	04/24/2023

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	This finding was reviewed with the D.O.C. and the A.I.T during the exit conference on 04/11/23 at 3:15 p.m. 3.1-19(b)		4 weeks of doors around the campus. As a means of quality assurance, results of the audits and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of two (2) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 4/24/2023.	