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	12/04/2024

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: 12/04/24 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 70. Quality Review completed on 12/06/24	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: 12/04/24 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	12/18/2024

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 70 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 12/06/24			
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure steel armover sprinkler pipes within 2 of 2 courtyards were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, at 9.2.3.5.1 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice	K 0351	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On December 11, 2024, an outside vendor installed supports to armover sprinkler pipes in both courtyards. **2. How other residents having**	12/20/2024

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	could affect all occupants in the facility. Findings include: Based on observations on 12/04/24 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Supervisor, there was a four inch sprinkler main which ran under the full length of each of the two courtyard building overhangs (east and west courtyards). There was a five foot section at the end of each four inch sprinkler main armover that was unsupported (two per each courtyard and four total). This was acknowledged by the Maintenance Supervisor at the time of each observation. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		**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 the courtyard have the potential to be affected by the alleged deficient practice. The Maintenance Director checked facilities supported armover to sprinkler, sprinkler drop, and sprig-up for proper support spacing. **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 the Environmental Director and Maintenance Director on the proper spacing/distance of the supported armover sprinkler pipe. **4. How the corrective action will be monitored to ensure the deficient will not recur i.e. what quality assurance program will be put into place?** Maintenance or his designee will monitor monthly times 4, the quarterly times 2. Any concerns/issues will be brought to the QAPI committee for review.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and	K 0353	**1. What corrective action(s) will**	12/20/2024

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	interview; the facility failed to document sprinkler system inspections fully in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 52 of the past 52 weeks for the sprinkler system's pressure gauges. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 12/04/24 between 9:45 a.m. and 12:00 p.m. with the Maintenance Supervisor present, there was documentation available to show the facility's dry sprinkler system gauges were inspected weekly during all 52 weeks of the past 12 month period, however, only 1 of the 3 sprinkler gauges were documented as being inspected each week. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was only 1 of the 3 sprinkler gauges documented as being inspected during the past 52 week period. Based on observations between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Supervisor, the facility had three pressure gauges		**be accomplished for those residents found to have been affected by the deficient practice?** On December 4, 2024, the Maintenance Director viewed and documented the inspection of the gauges after survey was completed. **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 the courtyard have the potential to be affected by the alleged deficient practice. The Maintenance Director inspected the facilities sprinkler system to verify and identify any other gauges on the system. **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 the Environmental Director and Maintenance Director on documenting inspection of all gauges on the sprinkler systems and added to Tels/inspection log. **4. How the corrective action will be monitored to ensure the deficient will not recur i.e. what quality assurance program will be put into place?**	

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	total, one at the sprinkler riser, and two on the four inch sprinkler main within the west courtyard. This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		Maintenance or his designee will monitor monthly times 4, the quarterly times 2. Any concerns/issues will be brought to the QAPI committee for review.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 2 of over 5 resident areas open to the corridor were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 12/04/24 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The Moving Forward Lounge was open to the egress corridor without full direct supervision from a 24 hour station (Nurse's Station).	K 0361	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On December 9, 2024, an outside vendor installed 2 electronically supervised automatic smoke detectors in the Moving Forward Lounge and 1 electronically supervised automatic smoke detector in the employee locker room. **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 the courtyard have the potential to be affected by the alleged deficient practice. The Maintenance Director reviewed facilities open areas to verify that all other areas were able to be viewed by the nurses station or have an electronically supervised	12/20/2024

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	b. The Employee Locker Room was open to and adjacent to the Employee Breakroom. The Employee Breakroom was open to the egress corridor without direct supervision from a 24 hour station (Nurse's Station). Furthermore, LSC 19.3.6.1(7) was not met because the Moving Forward Lounge and the Employee Locker Room were not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of each observation, the Maintenance Supervisor agreed the Moving Forward Lounge and Employee Locker Room were not provided with an electrically supervised automatic smoke detector or doors to the egress corridor and was not directly supervised by a 24 hour station (Nurses' Station). This finding was reviewed with the Executive Director and Maintenance Supervisor during the exit conference. 3.1-19(b)		automatic smoke detector. **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 the Environmental Director and Maintenance Director that current and any new open areas to a corridor must be viewed by the nurses station or have an electronically supervised automatic smoke detector. **4. How the corrective action will be monitored to ensure the deficient will not recur i.e. what quality assurance program will be put into place?** Maintenance or his designee will monitor monthly times 4, the quarterly times 2. Any concerns/issues will be brought to the QAPI committee for review.	