STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155808	A. BUILDING -- B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

(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: 04/23/24 Facility Number: 012937 Provider Number: 155808 AIM Number: 201208220 At this Emergency Preparedness survey, Wellbrooke of Westfield was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 70 certified beds. At the time of the survey, the census was 54. Quality Review completed on 04/25/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maggie Miller	Executive Director	05/09/2024

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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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §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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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, 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 incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:55 a.m. to 12:45 p.m. on 04/23/24, thirty-six month period emergency generator testing for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on review of the emergency generator inspection contractor's "3 Phase Load Bank Test (1)" dated 08/03/23, a 90-minute load test was conducted for the facility's emergency generator during the most recent twelve month period. Based on interview at the time of record review, the Facilities Management Support stated the four hour test was supposed to have been conducted in 2021 but was postponed due to the Covid-19 pandemic and was not performed in 2021 or after and agreed thirty-six month period emergency generator testing for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on observations with the DPO	E 0041	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review. **E 041 - LTC Emergency Power** **Immediate intervention** The generator service contractor was called to schedule immediately for the 4hr continuous load test to satisfy this deficient practice that could affect all residents, staff, and visitors. **Exhibit A – Documentation** The Director of Plant Operations was educated by the Regional	05/09/2024

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	and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, the facility has one diesel fired emergency generator located outside of the building on the south side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 200 kW. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference.		Support on NFPA 101 Electrical Systems, Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions includes a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) **Exhibit B – Inservice** The Director of Plant Operations will maintain testing records to ensure proper cycles of completion.	

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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: 04/23/24 Facility Number: 012937 Provider Number: 155808 AIM Number: 201208220 At this Life Safety Code survey, Wellbrooke of Westfield 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 two-story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels and corridors, spaces open to the corridors, and has hard-wired smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 70 and had a census of 54 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 04/25/24	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review.	
K 0222 SS=E	NFPA 101 Egress Doors			

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Bldg. 01	Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with			

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	7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted 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, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Director of Plant Operations (DPO) during the initial walk through	K 0222	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review.	05/09/2024

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	of the facility from 9:30 a.m. to 9:55 a.m. on 04/23/24, the entrance door set to the adjoining Legacy Hall which is an assisted living portion of the building was marked as a facility exit with an exit sign. The exit door set could be opened by entering a code into a keypad to release the door set to open but the code to release the door set to open was not posted at the exit door set. Based on observations with the DPO and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, the code to release the exit door set to open was still not posted at the exit door set into the Legacy Hall. Based on interview at the time of the observations, the DPO stated the code had been posted at the entrance door set to the Legacy Hall but agreed the exit door set to go into the Legacy Hall was marked as a facility exit but the code to release the door set to open was not posted at the exit door set. This finding was reviewed with the (DPO) and the Facilities Management Support during the exit conference. 3.1-19(b)		**K 222 - Egress Doors NFPA 101** **Immediate Intervention** The Director of Plant Operations has placed the code for the keypad for the door leading into the Memory care unit to allow access for visitors to the locked area. This deficiency could affect 20 residents, staff, and visitors. **Exhibit C – Photo** The Director of Plant Operations and ADPO was educated by Regional Facilities Support on maintaining the posting of the code on the keypad. Doors within a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless otherwise permitted in accordance with 19.2.2.2.5.2 **Exhibit B – Inservice** The Director of Plant Operations will perform monthly review X6. **Exhibit D – Audit tool.** Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 3 of over 16 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) and soiled linen/ trash collection rooms (exceeding 64 gallons) were separated from	K 0321	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on	05/09/2024

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	other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, the following was noted: a. the west door to the kitchen from the main dining room was equipped with a self closing device and a latching mechanism to latch the door into the door frame but the door failed to fully self close and latch into the door frame when tested to close multiple times. The kitchen contained soiled linen and trash carts exceeding 64 gallons. The main dining room was open to the corridor. b. the former Director of Plant Operations office identified as Room B64 by the breakroom in the service hall had been converted to a dietary storage room for combustible boxes and supplies. The room measured 64 square feet in size. The corridor door to the room was not equipped with a self closing device. c. the work area open to the service corridor outside the Electrical Room identified as Room B170 was used for shelf storage of combustible boxes and supplies with three deep fryer fluid storage containers also stored in this area which was greater than 50 square feet in size. The work area was not separated from other spaces by smoke resistant partitions and doors. Based on interview at the time of the observations, the DPO agreed the aforementioned three hazardous areas were not separated from other spaces by smoke resistant partitions and doors.		the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review. **K321** **Hazardous Areas – Enclosure** **Immediate intervention A** Director of Plant Operations adjusted door entering the kitchen to allow self-closing device to fully self-close into the frame. **Immediate intervention B** Director of Plant Operations installed a self-closing device to room B64 to allow latching into the frame. **Immediate intervention C** Director of Plant Operations emptied work area and all combustible items removed. These deficient practices could affect 20 residents, staff, and visitors. **Exhibit E – Photo** **Exhibit F - Photo** The director of plant operations was educated by Regional Support on NFPA 101- hazardous areas as regards to the corridor door to this room requiring a	

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	These findings were reviewed with the (DPO) and the Facilities Management Support during the exit conference. 3.1-19(b)		self-closing device in accordance with 8.7.1 or 19.3.5.9, 19.3.2.1 **Exhibit B – Inservice Documentation** The director of plant operations will visually inspect all doors that exit into the common corridor weekly x 3 months then monthly x3. **Exhibit G – Audit tool.** The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0344 SS=F Bldg. 01	NFPA 101 Fire Alarm - Control Functions Fire Alarm - Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72 Based on record review, observation and interview; the facility failed to ensure all fire alarm system emergency control functions were maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Table 14.4.5(18) states interface equipment and emergency control functions shall be tested annually. Table 14.4.2.2(23) defines smoke damper operation as an emergency control function. Testing frequency for emergency control function	K 0344	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is	05/09/2024

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	shall be the same as the initiating device that activates the emergency control function. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 02/05/24 with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:55 a.m. to 12:55 p.m. on 04/23/24, smoke damper testing documentation for the most recent twelve month period was not available for review. Based on observations with the DPO during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, one smoke damper was noted in HVAC ductwork above the suspended ceiling above the corridor door set at the entrance to the adjoining Legacy Hall which is an assisted living portion of the facility. During the tour, circuit breaker #5 in the "Life Safety" wall mounted electrical panel identified as "1XCRB1" in the Electrical Room identified as B134 by Room 205 was identified as "Fire Damper" which would indicate at least one mechanical smoke damper was located in the facility. Based on interview at the time of the observations, the DPO agreed the facility had at least one smoke damper in the facility and it could not be ensured all smoke dampers in the facility were inspected and tested within the most recent twelve month period. These findings were reviewed with the DPO and the Facilities Management Support during the exit		asking for paper compliance and a desk review. **K344 Fire Alarm – Control Functions** **Immediate Intervention** The Director of Plant Operations has contacted and scheduled Contractor (SafeCare) for inspection of the dampers for the campus. This deficient practice had the potential to affect all residents, staff, and visitors. **Exhibit H – Documentation** **Exhibit H1 - Documentation** The Director of Plant Operations was educated by Regional Support on LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing to be performed in accordance with Table 14.4.5 testing Frequencies. **Exhibit B – Inservice** The Director of Plant Operations will review all damper inspections 1 X month X 6 months. **Exhibit I – Audit tool.** The results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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	conference. 3.1-19(b)			
K 0345 SS=F 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 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include:	K 0345	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review. **K345 – Fire Alarm System – Test and Maintenance** **Immediate Intervention A** The Director of Plant Operation contacted the campus's vendor for	05/09/2024

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	Based review of the fire alarm system inspection contractor's "Fire Alarm Inspection and Testing Form" documentation dated 02/05/24 with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:55 a.m. to 12:55 p.m. on 04/23/24, visual semi-annual fire alarm system inspection documentation six months prior to 02/05/24 was not available for review. Based on interview at the time of record review, the DPO and the Facilities Management Support agreed visual semi-annual inspection documentation for the facility's fire alarm system six months prior to 02/05/24 was not available for review. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the fire alarm system to ensure that it had accurate time and date information in accordance with the requirements of NFPA 101, 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72, 2010 edition, Sections 14.1 and 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, the main fire alarm system control panel located near the elevator read the time of day as 1:50 p.m. at 2:39 p.m. Based on interview at the time of the		Fire Alarm Inspections. The contractor was able to make an adjustment to the date and time to the Fire Alarm Control Panel. **Exhibit J - Photo** **Immediate Intervention B** The Director of Plant Operations was able to locate the Semi-annual visual inspection for the campus. This deficient practice could affect all residents, staff, visitors. **Exhibit K – Documentation** The Director of Plant Operations was educated by Regional Support on NFPA 101, 2012 edition, 19.3.4, 9.6 and NFPA 72. 2010 edition, 14.1, 14.1.1 **Exhibit B - Inservice** The Director of Plant Operations will audit the Fire Alarm Control Panel. Once per month X 6 months. **Exhibit L – Audit tool.** The Director of Plant Operations will verify that semi-annual visual inspection is completed in a timely manner. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved.	

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	observations, the DPO agreed the main fire alarm system control panel displayed the incorrect time of day. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance	K 0353	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal	05/09/2024

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	between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Data Room identified as B122. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, a one half inch semi-circular gap was noted in between the escutcheon for the ceiling mounted sprinkler and the ceiling in the Data Room identified as B122 by Room 227. Based on interview at the time of the observations, the DPO agreed the semi-circular gap in the ceiling did not maintain the ceiling construction in the room. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review. **K353** **Sprinkler System – Maintenance and testing** **Immediate intervention** Ceiling surrounding Sprinkler head was sealed to provide a smooth ceiling and allow the sprinkler to operate at proper temperatures. This deficient practice could affect 10 residents, staff, and visitors in the vicinity of the data room. **Exhibit M – photo.** Director of plant operations was educated by Regional Support on K353 NFPA 101 Sprinkler System- Maintenance and testing. Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA25, Standard of inspection, Testing, and maintaining of water-based fire Protection systems, records of system design, maintenance, inspection, and testing are maintained in a secure location and readily available. Additionally, 9.7.5, 9.7.7, 9.7.8 and NFPA 13, 2010 edition Section 3.3.5.4. **Exhibit B – Inservice**	

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			Documentation The Director of Plant Operations will visually inspect all Sprinkler Heads once weekly for X3 months. Followed by once month X 3 **Exhibit N – Audit tool.** The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 16 portable fire extinguishers in the facility were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. This deficient practice could affect over 5 residents, staff and visitors.	K 0355	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review.	05/09/2024

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	Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, the ABC portable fire extinguisher located in the Salon was freestanding on the countertop by the sink by the corridor door to the room and was not secured. In addition, the ABC portable fire extinguisher located in the Therapy Room was freestanding on the floor near the laundry area of the room and was also not secured. The portable fire extinguisher inspection contractor had affixed maintenance tags to each extinguisher indicating annual maintenance for the fire extinguisher was performed in February 2024. The affixed maintenance tags also indicated monthly inspections by facility staff had been documented for March and April 2024. Based on interview at the time of the observations, the DPO agreed the aforementioned portable fire extinguishers were not securely installed. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		**Immediate intervention** Director of Plant Operations installed the extinguisher in the therapy gym and the extinguisher that was in the salon in accordance with NFPA 10, 2010 edition section 6.1.3.4, 6.1.3.8.1. This deficient practice could affect 5 residents, staff, and visitors. **Exhibit O -Photo** **Exhibit P – Photo** Director of Plant Operations was educated by Regional Support on K355 portable fire extinguishers NFPA 101. Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for portable fire Extinguishers 18.3.5.12, 19.3.5.12, NFPA10. **Exhibit B – Inservice** The Director of Plant Operations will visually inspect installation in accordance with NFPA10, once per month X6. **Exhibit Q – Audit tool.** The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC			

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	Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview; the facility failed to ensure 4 of 4 boilers which require inspection certificates from the State of Indiana had current inspection certificates to ensure the boilers were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:55 a.m. to 12:55 p.m. on 04/23/2/24, current inspection certificates from the State of Indiana for all boilers in the facility which require inspection certificates were not available for review. Current inspection documentation for the boilers was also not available for review. Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, the following boilers did not have current Certificate of Inspection documentation from the State of Indiana: a. the boiler identified as IN322825. b. the boiler identified as IN322826. c. the boiler identified as IN322827. d. the boiler identified as IN322828. Expired Certificate of Inspection documentation	K 0500	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review. **K500 – Building Services – Other** **Immediate Intervention** The Director of Plant Operations contacted the boiler division and was able to obtain current boiler certificates. This deficient practice could affect all residents, staff, and visitors. **Exhibit R – Documentation** **Exhibit S – Documentation** **Exhibit T – Documentation**	05/09/2024

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	from the State of Indiana was posted at each of the boiler locations indicating each Certificate expired 05/25/23. Based on interview at the time of record review and of the observations, the Facilities Management Support stated the units had been inspected but current Certificates were not available to download from the State's web site and agreed the aforementioned boilers did not have current Certificate of Inspection documentation from the State of Indiana. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		**Exhibit U – Documentation** Director of Plant Operations was educated by Regional Support on K500 NFPA 101 Section 19.1.1.3.1 that requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. **Exhibit B – Inservice** The Director of Plant Operations will maintain records of certificates as indicated in TELS. The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly,			

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	exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted	K 0918	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on April 23rd, 2024. Wellbrooke of Westfield is asking for paper compliance and a desk review.	05/09/2024

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	to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.1 states for a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. Section 8.4.9.5.2 states for a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Section 8.4.9.5.7 states where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:55 a.m. to 12:45 p.m. on 04/23/24, thirty-six month period emergency generator testing for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on review of the emergency generator inspection contractor's "3 Phase Load Bank Test (1)" dated 08/03/23, a 90-minute load test was conducted for the facility's emergency generator during the most recent twelve month period. Based on interview at the time of record review, the Facilities Management Support stated the four hour test was supposed to have been conducted in 2021 but was postponed due to the Covid-19 pandemic and was not performed in 2021 or after and agreed		**K918 – Electrical Systems** **Immediate Intervention** The generator service contractor was called to schedule immediately for the 4hr continuous load test to satisfy this deficient practice that could affect all residents, staff, and visitors. **Exhibit A - Documentation** The Director of Plant Operations was educated by the Regional Support on NFPA 101 Electrical Systems, Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions includes a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155808	A. BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF WESTFIELD	937 E 186TH STREET WESTFIELD, IN 46074

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	thirty-six month period emergency generator testing for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on observations with the DPO and the Facilities Management Support during a tour of the facility from 12:55 p.m. to 3:00 p.m. on 04/23/24, the facility has one diesel fired emergency generator located outside of the building on the south side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 200 kW. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) **Exhibit B - Inservice** The Director of Plant Operations will maintain testing records to ensure proper cycles of completion.	