STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155606	A. BUILDING -- B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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: 10/05/22 Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530 At this Emergency Preparedness survey, Westside Retirement Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 132 certified beds. At the time of the survey, the census was 90. Quality Review completed on 10/11/22	E 0000		
K 0000 Bldg. 03	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: 10/05/22 Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530 At this Life Safety Code survey, Westside	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	Retirement Village 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 was determined to be of Type II (000) 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. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 132 and had a census of 90 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered. Quality Review completed on 10/11/22			
K 0300 SS=E Bldg. 03	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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 observation and interview, the facility failed to replace battery operated smoke alarms installed in 1 of 75 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke	K 0300	**K300** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **The smoke alarm in Room 323 was replaced.**	10/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 323. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:45 p.m. on 10/05/22, manufacturer's documentation affixed to the BRK Model FG250 battery operated smoke alarm installed on the ceiling in resident sleeping Room 323 stated the unit was manufactured 06/26/12. Based on interview at the time of the observations, the Maintenance Director stated each resident sleeping room has the same type of battery operated smoke alarm installed in the room and agreed the battery operated smoke alarm installed in Room 323 was more than ten years old. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		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. **An audit of all resident room smoke alarms was conducted. Any smoke alarm noted with manufactures date greater than 10 years to be replaced.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **Maintenance director received education on NFPA 72 guideline, which states that smoke alarms cannot remain in service longer than 10 yrs. Replacement date (10 yrs from manufactured date) to be placed on the cover of all new alarms for visibility. Replacement date will be verified monthly upon monthly smoke alarm testing.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Maintenance director/designee will inspect and log monthly findings of all smoke alarms to include visibility of replacement date for 6 months.** The results of these will be review and discussed at the monthly facility QAPI for a total of 6 months. Frequency and duration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
			of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction. What date the systemic changes for each deficiency will be completed. October 23, 2022	
K 0325 SS=E Bldg. 03	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	460, 482, 483, and 485 Based on observation and interview, the facility failed to ensure alcohol based hand sanitizers were not installed over an ignition source in 1 of over 50 rooms. NFPA 101, in 19.1.1.3 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 could affect over 10 residents, staff and visitors in the vicinity of the Associates Breakroom by the entrance to the 200 Hall. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:45 p.m. on 10/05/22, an alcohol based hand sanitizer dispenser was installed on the wall inside the Associates Breakroom by the entrance to the 200 Hall directly above the light switch for the room by the corridor door. Manufacturer's documentation affixed to the container inside the dispenser stated it contained 70% alcohol. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the dispenser contained an alcohol based solution and agreed the dispenser was installed directly above the light switch for the room. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0325	**K325** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **The alcohol dispenser was removed from above the light switch.** 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. **All residents and staff could be affected. No resident or staff were effected.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **Maintenance director received education on the correct placement of alcohol dispensers. A complete audit was completed and any dispensers not properly placed was moved.** How the corrective action(s) 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 complete a monthly audit x 6 months of the facility to ensure alcohol dispensers are not installed above light switches.**	10/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
			The results of these will be review and discussed at the monthly facility QAPI for a total of 6 months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction. What date the systemic changes for each deficiency will be completed. October 23, 2022	
K 0761 SS=F Bldg. 03	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the	K 0761	**K 761** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **The fire door to the oxygen storage room by south nurse's station fire door was inspected on 10/7/2022. The fire door to the oxygen storage room by the north nurses' station was inspected on 10/7/2022. The fire door to the oxygen storage room in the charting room by north nurse's station was inspected on 10/7/2022.** 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. **This**	10/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors.		**deficient practice could affect all residents, staff and visitors. No resident, staff or visitor were affected.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **Maintenance director received education on the annual inspection and testing requirements of all fire door assemblies. All fire doors that are to be inspected have been labeled. Vendor informed of the location of oxygen storage room fire door for annual inspection purposes.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Maintenance director/designee and vendor will follow facility's fire door identification log as part of the annual fire door inspection to ensure all doors are inspected q12months.** The results of these will be review and discussed at the monthly facility QAPI for a total of 12 months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	Findings include: Based on record review with the Executive Director and the Maintenance Director from 9:30 a.m. to 12:15 p.m. on 10/05/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated he would contact the fire door inspection contractor who conducted the most recent inspection to try and obtain the inspection report during the Life Safety Code survey. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:45 p.m. on 10/05/22, three separate oxygen storage rooms were noted in the facility, each with a single leaf fire-rated door to the room. Each single leaf fire rated door was equipped with a 45 minute fire resistance rating label affixed to the hinge side of the door. The oxygen storage room by the south nurses's station by Room 100 had a total of five liquid oxygen containers and twelve 'E' type oxygen cylinders stored in the room. The oxygen storage room by the north nurses's station had a total of five liquid oxygen containers and one 'E' type oxygen cylinder stored in the room. The oxygen storage room in the charting room by the north nurses's station for the facility's piped gas system had a total of seven large liquid oxygen containers and thirteen 'E' type oxygen cylinders stored in the room. Based on review of the fire door inspection contractor's "Work Performed" documentation dated 08/25/22 for fire door inspections performed on 08/24/22 during the exit conference, a total of two single-leaf fire doors, each rated at 20 minutes fire resistance, were included with all fire doors inspected on 08/24/22. All fire doors inspected did not include the		What date the systemic changes for each deficiency will be completed. October 23, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	location of the doors and were identified by a numbering and lettering system. Based on interview at the time of the exit conference, the Maintenance Director agreed it could not be ensured the three oxygen storage room fire door locations were included in the 08/24/22 inspection documentation. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0907 SS=E Bldg. 03	NFPA 101 Gas and Vacuum Piped Systems - Maintenance Pr Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) Based on record review, observation and interview; the facility failed to maintain the facility's piped gas systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition. This deficient practice could affect over	K 0907	K907 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **The annual**	10/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	10 residents in the 300 Hall should the facility's pipe gas system not be operational. Findings include: Based on record review with the Executive Director and the Maintenance Director from 9:30 a.m. to 12:15 p.m. on 10/05/22, annual inspection documentation for the facility's piped gas systems within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated he would contact the piped gas system inspection contractor who conducted the most recent inspection to try and obtain the inspection report during the Life Safety Code survey. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:45 p.m. on 10/05/22, the facility has piped gas and vacuum systems serving resident sleeping rooms in the 300 Hall. Based on review of THE piped gas system inspection contractor's "Medical Gas Systems Annual Inspection Report" documentation dated 10/08/21 with the Executive Director and the Maintenance Director during the exit conference, deficiencies were noted by the contractor during their inspection. The report indicated there were deficiencies with the oxygen manifold and the ventilation of the liquid oxygen storage room for the piped gas system. Deficiencies were also noted for outlets in Room 313, Room 326 and Room 331. Based on interview at the time of the exit conference, the Maintenance Director stated repair documentation on or after 10/08/21 was not available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.		**piped gas inspection was conducted on 10/08/21.** 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. **This alleged deficient practice could affect over 10 residents in the 300 Hall. No residents were affected.** What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. **Maintenance director received education on the maintenance requirement for the facility's piped gas system. Yearly inspection was less than a year ago on 10/8/2021. Vendor has been prepaid for the 2022 annual inspection and repair recommendations.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. **Vendor paid in full for current year (2022) annual pipe gas inspection. Facility awaits scheduling by vendor. Annual Pipe Gas inspection has been added to maintenance calendar to ensure timely completion prior to inspection expiration.** The results of these will be review and discussed at the monthly facility QAPI for a total of 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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
	3.1-19(b)		months. Frequency and duration of review will be increased as needed if any areas of noncompliance are identified during the auditing process. Administrator is responsible in ensuring compliance in this plan of correction. What date the systemic changes for each deficiency will be completed. October 23, 2022	