STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155170	A. BUILDING -- B. WING	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE MUNCIE INC	5801 W BETHEL AVE MUNCIE, IN 47304

(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: 06/11/24 Facility Number: 000086 Provider Number: 155170 AIM Number: 30067850 At this Emergency Preparedness survey, Westminster Village Muncie Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 76 and had a census of 57 at the time of this survey. Quality Review completed on 06/12/24	E 0000	**The submission of this Plan of Correction (HCFA-2567) does not constitute an admission by Westminster Village Muncie, Inc. of any fact or conclusion set forth in the Statement of Deficiencies. This Plan of Correction is being submitted because it is required by law.** **Furthermore, we request that this Plan of Correction serve as our credible allegation of compliance.** **Compliance is effective: June 25, 2024** **Mary Jo Crutcher, HFA** **President and Administrator** **June 21, 2024** **Date**	
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).	K 0000	**The submission of this Plan of Correction (HCFA-2567) does not constitute an admission by Westminster Village Muncie,**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Jo Crutcher	HFA, President	06/21/2024

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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	Survey Date: 06/11/24 Facility Number: 000086 Provider Number: 155170 AIM Number: 30067850 At this Life Safety Code survey, Westminster Village Muncie Inc. 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident rooms. The facility has a capacity of 76 and had a census of 57 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/12/24		**Inc. of any fact or conclusion set forth in the Statement of Deficiencies. This Plan of Correction is being submitted because it is required by law.** **Furthermore, we request that this Plan of Correction serve as our credible allegation of compliance.** **Compliance is effective: June 25, 2024** **Mary Jo Crutcher, HFA** **President and Administrator** **June 21, 2024** **Date**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			

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	18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect as many as 10 residents, 4 staff, and 2 visitors. Findings include: Based on observations made during a tour of the facility on 06/11/24 at 1:05 p.m. with the Physical Plant Manager and the Assistant Physical Plant Manager, there were three nonambulatory residents sitting in reclining wheelchairs and one resident sleeping in a recliner on the Abbey wing directly across from the nurse's station, totally blocking the corridor. These residents were arranged in a way that impeded the corridor such that no one could bypass them without having to unlock the wheels on the seated recliners to have them moved to clear the corridor in the event of an emergency. Based on interview at the time of the observations, the Physical Plant Manager agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Executive Director/Administrator, the Physical Plant Manager, the Assistant Physical Plant Manager, and the Executive Assistant at the exit conference held on 06/11/24 at 2:55 p.m. 3.1-19(b)	K 0211	ID PREFIX TAG K211 SS=E- Egress Corridors 1. The three residents sitting in reclining wheelchairs blocking the corridor were immediately moved to another location. 2. All Nursing Staff members will be in-serviced on the regulatory guidance regarding keeping the means of egress free of all obstructions or impediments in case of fire or other emergencies. 3. This will prevent obstruction from any egress with on-going in-servicing providing education to all Nursing Staff. 4. Any concerns will be carried to the monthly Quality Assurance Committee meeting for the next nine months. 5. Date of compliance: 6/25/24	06/25/2024
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 8 exit doors was readily and easily accessible for residents, staff, and visitors use. This deficient practice could affect 12 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility on 06/11/24 at 1:27 p.m. with the Physical Plant Manager and the Assistant Physical Plant Manager, the exit door to the outside on the Bristol wing nearest to resident room #25 required heavy force to open when the door was pushed. Based on interview at the time of observation, the Physical Plant Manager acknowledged that the	K 0222	ID PREFIX TAG K222 SS=E – Egress Doors 1. During the observation walkthrough of doors were checked for impediment to opening and closing. One exit door to the outside on the Bristol Unit nearest B25 room noted to be difficult in opening and was repaired by adjusting the hinges and corrected within an hour of the finding. 2. All other doors were also checked immediately for proper opening and closing and all found to be in working order. 3. Skilled Care Maintenance	06/25/2024

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	exit door required heavy force to open adding that he would have one of his staff work on the door as soon as he could have a work order filled out to alleviate the issue. This finding was reviewed with the Executive Director/Administrator, the Physical Plant Manager, the Assistant Physical Plant Manager, and the Executive Assistant at the exit conference held on 06/11/24 at 2:55 p.m. 3.1-19(b)		Employee/Designee completes a weekly check list that includes checking the door latches and alarms by opening and closing each door. See attached completed lists. 4. The door weekly check list had not yet been completed for the week for the door in question. It was repaired within an hour of the finding. Any concerns will be taken to Quality Assurance Committee meeting for the next nine months. 5. Date of Compliance 6/25/24.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room was provided with properly working mechanical ventilation. This deficient practice could affect 14 residents, 4 staff and 2 visitors. Findings include:	K 0927	ID PREFIX TAG K927 SS=E – Oxygen Room Ventilation 1. The ventilation to the oxygen room was not working properly the day of the inspection. It was examined and found to have a broken belt on the vent motor.	06/25/2024

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	Based on observations made during a tour of the facility on 06/11/24 at 1:38 p.m. with the Physical Plant Manager and the Assistant Physical Plant Manager, the oxygen storage room had approximately 24 green oxygen tanks inside it. There was a mechanically ventilated exhaust fan in the ceiling of this room, however, it was not working at the time of observation. This was tested by holding s small piece of paper up to the vent, but the vent was not working. This was acknowledged by the Physical Plant Manager who added that he thought the belt may have slipped or broken on the fan unit above the room. This finding was reviewed with the Executive Director/Administrator, the Physical Plant Manager, the Assistant Physical Plant Manager, and the Executive Assistant at the exit conference held on 06/11/24 at 2:55 p.m. 3.1-19(b)		The belt was replaced on June 12, 2024 and all is in working order currently. 2. Please see attached pictures of the replaced belt and a tissue test of correctly functioning ventilation in the oxygen room. Skilled Care Maintenance Employee/Designee will check weekly that the ventilation is working properly in the oxygen room with a new checklist created. See attached list. Any concerns will be taken to Quality Assurance Committee meeting for the next nine months. 3. Date of Compliance 6/25/24.	