CENTERS FOR	ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039						
	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155389	A. BUILDING B. WING		COMPLETED 04/03/2023		
		100000			04/03/2023		
NAME OF P	ROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP COD				
WESTPA	RK A WATERS CO	DMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTI		(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
E 0000							
Bldg							
Diag	An Emergency Prer	paredness Survey was	E 0000	The following Plan of Correct	ion		
		diana Department of Health in	L 0000	constitutes the facility's writte			
	accordance with 42			allegation of compliance for t			
				deficiency cited. However,			
	Survey Date: 04/03	3/23		submission of this Plan of Correction is not an admissio	on to		
	Facility Number: 0	00473		and does not constitute an	1110		
	Provider Number:	155389		agreement with alleged			
	AIM Number: 100	290410		deficiencies herein. The Plar			
	Add T	D 1		Correction is submitted to me			
		Preparedness survey, Community was found in		the requirements established	-		
	-	nergency Preparedness		the state and federal regulation	JIIS.		
	-	Sedicare and Medicaid		The facility requests a desk			
	-	lers and Suppliers, 42 CFR		review.			
	483.73.	, - <u>-</u>		Townsum			
	The facility has 89 (certified beds. At the time of					
	the survey, the cens	us was 38.					
	Quality Review cor	mpleted on 04/11/23					
K 0000							
Bldg. 01							
	A Life Safety Code	Recertification and State	K 0000	The following Plan of Correct	ion		
	-	as conducted by the Indiana	110000	constitutes the facility's writte			
	Department of Heal	th in accordance with 42 CFR		allegation of compliance for the			
	483.90(a).			deficiency cited. However,			
				submission of this Plan of			
	Survey Date: 04/03	3/23		Correction is not an admissio	n to		
	E1114-101 1 0	00472		and does not constitute an			
	Facility Number: 0			agreement with alleged			
	Provider Number: 100			deficiencies herein. The Plan			
	AIM Number: 1002	∠20 1 10		Correction is submitted to me the requirements established			
	At this Life Safety	Code survey, Westpark A		the state and federal regulation	- 1		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Kesha LaGrone HFA 04/18/2023

Any defiency statement 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155389		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/03/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	with Requirements Medicare/Medicaid Life Safety from Fir National Fire Protec Life Safety Code (I	was found not in compliance for Participation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.		The facility requests a desk review.			
	the original section (200) construction a was determined to be the facility is fully fire alarm system we corridors and in all the facility has sme fire alarm system in the entire facility we construction. The facility we construction.	ity consisted of two sections: determined to be Type III and an addition, built in 2003 be Type V (000) construction. sprinklered. The facility has a ith smoke detection in the areas open to the corridor. bke detectors hard wired to the all resident sleeping rooms. vas surveyed as Type V (000) facility has a capacity of 89 and at the time of this visit.					
	access were sprinkled detached storage shaprinklered.						
K 0100 SS=E Bldg. 01	NFPA 101 General Requirem General Requirem List in the REMAR Section 18.1 and that are not addre K-tags, but are de along with the app NFPA standard cir on Form CMS-256	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, slicable Life Safety Code or tation, should be included 67.	W 0100				
		on and interview, the facility 4 corridor door sets would	K 0100	K100 – It is the intent of the factor to ensure corridor door sets we	•		

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Event ID:

U4J721

Facility ID: 000473

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPL			
		155389	B. W	ING		04/03/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			TIBBS AVE		
WESTD	ARK A WATERS CO				IAPOLIS, IN 46222		
WESTF	ARK A WATERS CO	JIMINIONI I I		INDIAN	IAPOLIS, IN 40222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X	(5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPL	ETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	ſΈ
	self-close and latch	into the door frame per			self close and latch into the do	or	
	4.6.12.3. LSC 4.6.	12.3 requires existing life safety			frame per 4.6.12.3 to meet se	İ	
	features obvious to	the public if not required by			standards.		
	the Code, shall be	either maintained or removed.			1. CORRECTIVE ACTIONS	3	
	This deficient pract	tice could affect over 20			TAKEN:		
	residents, staff, and	l visitors in the vicinity of the			a. On 4/18/2023 the		
	corridor door set by	y Room 6.			Maintenance Supervisor/design	jnee	
					made repairs to the west door	in	
	Findings include:				the corridor door set by Room	6 to	
					ensure the door fully self close	es	
	Based on observations with the Maintenance				and latches into the door fram	e to	
	Assistant during a tour of the facility from 9:05				meet set standards. The		
	a.m. to 11:20 a.m. on 04/03/23, the west door in the				Administrator verified the worl	con	
	corridor door set by Room 6 was held in the fully				4/18/2023.		
	open position with	a magnetic hold open device			2. ALL OTHERS WITH		
	set to release with t	fire alarm system activation,			POTENTIAL TO BE AFFECTI	ED:	
	latching hardware a	and a self-closing device but			a. All residents and all staf	:	
	the door failed to so	elf-close and latch into the			and visitors have the potential	to	
	door frame when to	ested to close multiple times.			be affected but none were. O	n	
	Based on interview	at the time of the			4/18/2023 the Maintenance		
	observations, the M	Saintenance Assistant agreed			Supervisor/designee inspecte	lla b	
	the west door in the	e door set by Room 6 would			corridor doors throughout the		
	not fully self-close	and latch into the door frame.			facility and found no other neg	ative	
					findings.		
		eviewed with the Executive			3. MEASURES TO PREVE	NT	
		enance Director, and the			REOCCURRENCE:		
	Maintenance Assis	tant during the exit			a. On 4/18/2023 the		
	conference.				Administrator inserviced the		
					Maintenance Supervisor/desig	jnee	
	3.1-19(b)				on the requirement that corrid	or	
					doors must fully self close and	ſ	
					latch into the frame to meet se	et	
					standards.		
					b. Maintenance		
					Supervisor/designee will inspe		
					all corridor doors throughout t	пе	
					facility monthly to ensure they		
					fully self close and latch into t	ne	
					frame as a part of the facility's		
					Preventive Maintenance Prog		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155389	B. WING 04/03/2023			/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER	8			TIBBS AVE			
WESTPA	ARK A WATERS CO	DMMUNITY			IAPOLIS, IN 46222			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLUDED OF AN OF CODE CODE		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					and document those inspectio	n		
					results as appropriate. If any			
					issues are discovered, they wi	ill be		
					addressed and resolved			
					immediately. The Maintenanc	:e		
					Supervisor/designee will revie	W		
					with the Administrator the			
					inspection results.			
					c. The Administrator will			
					monitor adherence to the			
					Preventative Maintenance			
					schedule and validate the			
					Preventative Maintenance			
					documentation is in place.			
					4. MONITORING			
					CORRECTIVE ACTION:			
					a. The inspection results w			
					be presented by the Maintena	nce		
					Supervisor/designee to the			
					Administrator monthly and the			
					Administrator will present the			
					inspection results at the month	-		
					Quality Assurance/Performand			
					Improvement (QA/PI) meeting			
					Inspection results and system			
					components will be reviewed I	эу		
					the QA/PI Committee with	_		
					subsequent plans of correction			
					developed and implemented a	IS		
					deemed necessary to ensure			
					compliance is maintained.			
					This plan of correction			
					constitutes our credible	h		
					allegation of compliance with	I		
					all regulatory requirements.			
					Our date of compliance is 4/19/2023.			
					 			
K 0291	NFPA 101							
SS=F	Emergency Lightin	na						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPLETED			ETED
		155389	B. W	ING _	04/03/2023		/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			TIBBS AVE		
WESTPA	RK A WATERS CO	OMMUNITY		INDIANAPOLIS, IN 46222			
(VA) ID	CIRALANY	CT A TEMPLIT OF DEFICIENCIE	1		T		(7/5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
Bldg. 01		R LSC IDENTIFYING INFORMATION	TAU			DATE	
Diag. 01	Emergency Lightin	g of at least 1-1/2-hour					
		ed automatically in					
	accordance with 7						
	18.2.9.1, 19.2.9.1	.5.					
		on and interview, the facility	$ _{K0}$	291	K291 – It is the intent of the		04/19/2023
		f 8 battery powered emergency	I K U	271	facility to ensure battery power	red	04/17/2023
		s maintained in accordance			emergency lighting systems a		
		.9. LSC 7.9.2.6 states battery			maintained in accordance with		
		lights shall use only reliable			LSC Section 7.9 to meet set	•	
		le batteries provided with			standards.		
	1	r maintaining them in properly			1.CORRECTIVE ACTIONS		
		Batteries used in such lights			TAKEN:		
	or units shall be approved for their intended use				1.On 4/18/2023 the		
		ith NFPA 70, National Electric			Maintenance Supervisor/desig	gnee	
	Code. This deficien	nt practice could affect all			repaired the exit light affixed to		
	residents, staff and	visitors if needing to exit the			wall above the door set in the		
	facility from the ma	in entrance lobby.			entrance lobby to ensure it is		
					working to meet set standards	S.	
	Findings include:				The Administrator verified the		
					testing on 4/18/2023 .		
	Based on observation	ons with the Maintenance			2.ALL OTHERS WITH		
	_	our of the facility from 9:05			POTENTIAL TO BE AFFECTI	ED:	
		on 04/03/23, the battery-operated			1.All residents and all sta	aff	
		xed to the wall above the door			and visitors have the potential	to	
		ance lobby failed to illuminate			be affected but none were.		
	_	test button was pushed			3.MEASURES TO PREVEN	Т	
	_	sed on interview at the time of			REOCCURRENCE:		
	1	e Maintenance Assistant			1.On 4/18/2023 the		
		ntioned battery powered			Administrator inserviced the		
		system failed to illuminate			Maintenance Supervisor/desig	•	
	_	test button was pushed			on the requirement to provide		
	multiple times.				maintain exit lighting including		
	This find:	riarrad with the Ever-estima			illumination to meet set standa	ards.	
		viewed with the Executive			2.Maintenance	: al a	
	Maintenance Assist	enance Director, and the			Supervisor/designee will provi		
	conference.	ant during the exit			and maintain exit lighting mon	-	
	conference.				including proper illumination a		
	2 1 10(b)				part of the facility's Preventive	;	
	3.1-19(b)		1		Maintenance Program and		I

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	O1 COMPLETED		ETED
		155389	B. W	NG		04/03/	2023
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	K		1316 N	TIBBS AVE		
WESTPA	ARK A WATERS C	OMMUNITY		INDIAN	IAPOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORREC		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
					document those tests on the		
					Battery-Operated Exit Lights a	and	
					signs Inspection Log and will		
					maintain emergency lighting to	0	
					meet set standards. If any		
					issues are discovered, they w	III be	
					addressed and resolved	_	
					immediately. The Maintenand		
					Supervisor/designee will revie with the Administrator the	·W	
					inspection results.		
					3.The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.		
					4.MONITORING CORRECT	IVE	
					ACTION:		
					1.The inspection results	will	
					be presented by the Maintena	nce	
					Supervisor/designee to the		
					Administrator monthly and the	:	
					Administrator will present the		
					inspection results at the month	•	
					Quality Assurance/Performan		
					Improvement (QA/PI) meeting		
					Inspection results and system		
					components will be reviewed the QA/PI Committee with	Uy	
					subsequent plans of correction	n	
					developed and implemented a		
					deemed necessary to ensure		
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	h	
					all regulatory requirements.		
					Our date of compliance is		
					4/19/2023.		

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Event ID:

U4J721

Facility ID: 000473

If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE CO A. BUILDING B. WING	Onstruction 01	(X3) DATE SURVEY COMPLETED 04/03/2023	
	PROVIDER OR SUPPLIE		1316 N	ADDRESS, CITY, STATE, ZIP COD TIBBS AVE IAPOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire automatic fire ext accordance with approved automatoption is used, the from other space partitions and doe Doors shall be seautomatic-closing nonrated or field-do not exceed 48 the door. Describe the floor hazardous areas REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fueb. Laundries (large. Repair, Mainted. Soiled Linen Regallons) e. Trash Collection (exceeding 64 gas f. Combustible St. (over 50 square forms)	are protected by a fire four fire resistance rating a rated doors) or an inguishing system in 8.7.1 or 19.3.5.9. When the stic fire extinguishing system areas shall be separated as by smoke resisting or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A I-Fired Heater Rooms for than 100 square feet) mance, and Paint Shops sooms (exceeding 64 on Rooms llons) orage Rooms/Spaces eet) of classified as Severe				
		on and interview, the facility of over 8 hazardous areas such	K 0321	K321 – It is the intent of the factor to ensure hazardous areas such	•	

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as combustible storage areas (over 50 square feet

from other spaces by smoke resistant partitions

in size) and fuel fired heater rooms were separated

Event ID:

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Facility ID: 000473

If continuation sheet

as combustible storage area (over

50 square feet in size) and fuel

fired heater rooms are separated

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	a. building <u>01</u>			
		155389	B. WING		COMPLETED 04/03/2023		
		<u> </u>	ompress.	ADDRESS CITY STATE TO SEE			
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD			
///ESTD	DK V MVLEDS CO	MMI INITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
VVESIPA	ARK A WATERS CO		INDIAN	MAPOLIO, IIN 40222			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		hall be self-closing or		from other spaces by smoke			
	_	n accordance with 7.2.1.8. This		resistant partitions and doors	to		
	_	ould affect over 20 residents,		meet set standards.			
	staff, and visitors.			1. CORRECTIVE ACTIONS	6		
				TAKEN:			
	Findings include:			a. On 4/18/2023 the			
				Maintenance Supervisor/desig	•		
		ons with the Maintenance		repaired the self closing devic			
		aintenance Assistant during a		the active door leak in the cor			
	tour of the facility from 9:05 a.m. to 11:20 a.m. on			door set to the Central Supply			
04/03/23, the following was noted:			Room to ensure door self clos				
a. the active door leaf in the corridor door set to			and latches into the frame to r				
	the Central Supply Room was equipped with a			set standards. The Administra			
	self-closing device but the door failed to fully			verified the work on 4/18/2023	3.		
	self-close and latch into the door frame when			b. On 4/18/2023 the			
		riple times. The room was used		Maintenance Supervisor/desig	gnee		
		e boxes and supplies and was		repaired the 3/4" gap with an			
	larger than 50 squar			approved fire rated material or			
		was noted between the face		corridor door to the Maintenar			
		door stop near the floor for		Room by the Med Prep/Oxyge			
		the Maintenance Room by the		Room by the west nurse's sta	ition		
		Room by the west nurse's or was in the fully closed and		to meet set standards. The	(an		
		•		Administrator verified the work	COII		
	gas fired water heat	he room contained two natural		4/18/2023 . c. On 4/18/2023 the			
	l -	eight-inch hole was noted in		c. On 4/18/2023 the Maintenance Supervisor/desig	inee		
		ndry Utilities Room just above		1) repaired the eight in			
		utlet box which was broken		by eight inch hole with a one h			
		er plate. A long rectangular		fire rated material in the wall of			
		l in the wall just below the		laundry utilities room 2) Install			
		he room contained four natural		new wall mounted outlet box a			
	gas fired water heat			cover plate 3) repaired the hol			
	Based on interview			with a one hour fire rated mate			
		Iaintenance Director and the		in the wall just below the same			
	Maintenance Assist			outlet box to meet set standar			
		zardous areas were not		The Administrator verified the			
		er spaces by smoke resistant		on 4/18/2023 .			
	partitions and doors			2. ALL OTHERS WITH			
	1			POTENTIAL TO BE AFFECTE	ED:		

This finding was reviewed with the Executive

All residents and all staff

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	OF CORRECTION	IDENTIFICATION NUMBER 155389	A. BUILDING B. WING	01	COMPLETED 04/03/2023
	PROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE JAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Director, the Mainte Maintenance Assist conference. 3.1-19(b)	enance Director, and the ant during the exit		and visitors have the potential be affected but none were. Of 4/18/2023 the Maintenance Supervisor/designee inspects hazardous areas for holes and self-closing devices and foun other negative findings. 3. MEASURES TO PREVINTECT REOCCURRENCE: a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designee that all hazardous areas remain free holes/penetrations and must self-closing devices to meet standards. b. Maintenance Supervisor/designee will inspall hazardous area doors throughout the facility monthlensure they remain free of holes/penetrations and have closing devices as a part of the facility's Preventive Maintenane Program and document those inspection results as approprif any issues are discovered, will be addressed and resolve immediately. The Maintenan Supervisor/designee will review the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING	ed all ad ad ano ENT gnee of have set ect y to self ne nce ediate. they ed ce

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE S COMPLE 04/03/2	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION VULD BE PROPRIATE	(X5) COMPLETION DATE	
K 0351 SS=F Bldg. 01	by construction tyl throughout by an a sprinkler system in 13, Standard for the Systems. In Type I and II con protection measur substituted for spring areas where state sprinklers. In hospitals, sprinklers	Installation nd hospitals where required		a. The inspection reside presented by the Ma Supervisor/designee to Administrator monthly a Administrator will present inspection results at the Quality Assurance/Performerovement (QA/PI) months and someonents will be revisted QA/PI Committee where the QA/PI Committee where the QA/PI Committee which are the compliance is maintained. This plan of correction constitutes our credible allegation of compliance all regulatory requirem. Our date of compliance 4/19/2023.	sults will intenance the nd the nt the monthly ormance leeting. ystem lewed by ith rrection ented as insure led. le ce with lents.		

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Event ID:

U4J721

Facility ID: 000473

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155389		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/03/2023			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, 19.3.5.5, 19.4.2, 19.3.5.5, 19.4.2, 19.3.5.6 and observation failed to maintain the over 50 rooms in acceptance of the Instance of Instance	ons with the Maintenance aintenance Assistant during a from 9:05 a.m. to 11:20 a.m. on wing ceiling mounted sprinkler sing its escutcheon: In by the Accounting Inear the main entrance lobby. It is provided by the restroom Ince lobby. It is estimated by the Records Office. It is at the time of the It is a sprinkler It is mounted sprinkler	K 0351	K351 - It is the intent of the fato ensure to maintain the cei construction in rooms in accordance with NFPA 13, Standard for the installation of sprinkler systems to meet set standards. 1. CORRECTIVE ACTION TAKEN: a. On 4/18/2023 the Maintenance Supervisor/desinstalled the missing escutchings on the ceiling mounted sprinklers in the following locations: 1) in the copier root the Accounting Department (near the main entrance lobby the closet in room 8 3) in the equipment/server room by the restroom near the main entral lobby 4) in the women's restricted by the scheduler/medical recoffice 5) in the closet in room meet set standards. The Administrator verified the installation on 4/18/2023. 2. ALL OTHERS WITH POTENTIAL TO BE AFFECT a. All residents and all stand visitors have the potential be affected but none were. 3. MEASURES TO PREV REOCCURRENCE:	of of ot st IS signee seon om by Office y 2) in elector ance room cords a 45 to IED: of		

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/03/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	Director, the Maint Maintenance Assist conference. 3.1-19(b)	enance Director, and the tant during the exit		a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/des on the requirement that ceilir mounted sprinkler locations r be maintained including the escutcheon ring installed to r set standards. b. A Certified sprinkler contractor/Maintenance Supervisor/designee will insp all sprinkler heads monthly to ensure they are maintained a have the escutcheon ring ins as a part of the facility's mon Preventive Maintenance Pro and document those inspecti results as appropriate. If an issues are discovered, they w addressed and resolved immediately. The Maintenan Supervisor/designee will revi with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. MONITORING CORRECTIVE ACTION: a. The inspection results w be presented by the Mainten Supervisor/designee to the Administrator monthly and th Administrator will present the inspection results at the mon Quality Assurance/Performar Improvement (QA/PI) meetin	must meet pect pand talled thly gram on y vill be pee ew will ance e thly nce		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		A. BUILDING B. WING	01	COMPLETED 04/03/2023	
	ROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP COD TIBBS AVE IAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/19/2023.	n s
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkler are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any reautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on observate failed to maintain 1 accordance with LS	supply source RKS information on non-required or partial r system. and NFPA 25 tion and interview, the facility of 1 sprinkler system in C 9.7.5. LSC 9.7.5 requires all	K 0353	K353 – It is the intent of the facility to ensure sprinkler systems are in accordance with	04/19/2023
	*	systems shall be inspected ecordance with NFPA 25,		LSC 9.7.5 and to ensure to maintain the ceiling construction	on

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	ETED	
		155389	B. W	ING		04/03/	
					_		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					TIBBS AVE		
WESTPA	ARK A WATERS CO	DMMUNITY		INDIAN	IAPOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Standard for the Ins	spection, Testing, and			in rooms to meet set standard	S.	
	Maintenance of Water-Based Fire Protection						
	Systems. NFPA 25, 2011 edition, Section 5.2.2.2				1.CORRECTIVE ACTIONS		
	requires sprinkler piping shall not be subjected to				TAKEN:		
	external loads by m	aterials either resting on the			1.On 4/18/2023 the		
	pipe or hung from t	he pipe. This deficient practice			Maintenance Supervisor remo	ved	
	could affect all occ	upants.			the blue data cables that were	:	
					laying on top of horizontal		
	Findings include:				sprinkler piping in the attic abo	ove	
					the corridor ceiling as observe	ed	
	Based on observations with the Maintenance				from the attic access door out	side	
	Director and the Maintenance Assistant during a				room 7 to meet set standards.		
	tour of the facility from 9:05 a.m. to 11:20 a.m. on				The Administrator verified the	work	
	04/03/23, blue data	cables were laying on top of			on 4/18/2023 .		
	horizontal sprinkler	piping in the attic above the			2.On 4/18/2023 the		
	corridor ceiling as	observed from the attic access			Maintenance Supervisor/desig	gnee	
	door outside Room	7. Based on interview at the			realigned the two suspended		
	time of the observa	tions, the Maintenance			ceiling tiles in the laundry utilit	ies	
	Director and the Ma	aintenance Assistant agreed			room that were misaligned in	the	
	sprinkler piping wa	s used to support non-system			ceiling tile grid to meet set		
	components in the	attic near Room 7.			standards. The Maintenance		
					Supervisor/designee sealed the	ne	
		viewed with the Executive			six inch hole with a one hour f	ire	
		enance Director, and the			rated material that was noted	in a	
	Maintenance Assist	tant during the exit			ceiling tile in the room for the		
	conference.				passage of a red water line		
					through the ceiling tile to meet	set	
	3.1-19(b)				standards. The Maintenance		
					Supervisor/designee repaired		
		ration and interview, the			six inch by one inch hole with		
	I	intain the ceiling construction			one hour fire rated material the		
		ns. NFPA 13, 2010 edition,			was noted in a ceiling tile in th	е	
		nes a smooth ceiling as a			closet in room 45 to meet set		
	continuous ceiling free from significant				standards. The Administrator		
	irregularities, lumps, or indentations. The ceiling				verified the work on 4/18/2023	3.	
	traps hot air and gases around the sprinkler and				2.ALL OTHERS WITH		
		to operate at a specified			POTENTIAL TO BE AFFECTE		
		on 8.5.4.1.1 states the distance			1.All residents and all sta		
	_	er deflector and the ceiling			and visitors have the potential	to	
	above shall be selected based on the type of				be affected but none were.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155389	B. W	ING		04/03/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			TIBBS AVE		
WESTDA	ARK A WATERS CO				APOLIS, IN 46222		
WESTER	NIN A WATERS CO	SIMINORI I		INDIAN	AFOLIS, IN 40222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		pe of construction. This			3.MEASURES TO PREVEN	Т	
	deficient practice could affect over 20 residents,				REOCCURRENCE:		
	staff, and visitors.				1.On 4/18/2023 the		
					Administrator inserviced the		
	Findings include:				Maintenance Supervisor/desiç	jnee	
					on the requirement that the		
		ons with the Maintenance			sprinkler system must be prop	-	
		aintenance Assistant during a			maintained including no items		
		from 9:05 a.m. to 11:20 a.m. on			resting on the pipes and to en		
	_	ended ceiling tiles in the			ceiling construction is maintai		
	-	oom were misaligned in the			including no penetrations to m	ıeet	
		ich did not maintain the ceiling			set standards.		
	construction. A six-inch hole was also noted in a				2.Maintenance		
	-	oom for the passage of a red			Supervisor/designee will ensu		
	_	the ceiling tile. In addition, a			the sprinkler systems are prop	-	
	-	h hole was noted in a ceiling			maintained including no items		
		Room 45. Based on interview			resting on the pipes and to en		
		bservations, the Maintenance			ceiling construction is maintai		
		aintenance Assistant agreed			including no penetrations as a	-	
	-	ot properly aligned in the			of the facility's monthly Prever	ntive	
		had holes in the tiles at the			Maintenance Program and		
	aforementioned loc	eations.			document those inspection re-		
					as appropriate. If any issues		
		eviewed with the Executive			discovered, they will be addre		
		enance Director, and the			and resolved immediately. Th		
	Maintenance Assis	tant during the exit			Maintenance Supervisor/desig	_	
	conference.				will review with the Administra	itor	
	2.1.10(1.)				the inspection results.		
	3.1-19(b)				3.The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		
					documentation is in place.	N/E	
					4.MONITORING CORRECT	IVE	
					ACTION:	a dill	
					1.The inspection results		
					be presented by the Maintena	nce	
					Supervisor/designee to the		
	I		1		Administrator monthly and the	;	I

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/03/2023
	ROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP C I TIBBS AVE NAPOLIS, IN 46222	OD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION DATE
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or complements of the covering is not exceed to covering its not exceed to cove	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain		Administrator will press inspection results at the Quality Assurance/Per Improvement (QA/PI) respection results and components will be revented the QA/PI Committee was subsequent plans of condeveloped and implemed deemed necessary to ecompliance is maintain. This plan of correction constitutes our credit allegation of compliant all regulatory requirer. Our date of compliance 4/19/2023.	e monthly formance meeting. system viewed by with prrection ented as ensure ned. n ble nce with ments.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2023		
	PROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE NAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	applied. There is closing of the door release when the permitted. Nonrate unlimited height at meeting 19.3.6.3.6 frames shall be lated other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restrit resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection rating devices, etc. Based on observation failed to ensure 1 of sleeping rooms had latching into the doop passage of smoke. Affect over 10 resident vicinity of resident Findings include: Based on observation Assistant during a trans. to 11:20 a.m. or resident sleeping Redoor frame when te The latching mechal protrude into the latt Based on interview.	fire window assemblies are a sprinklered compartments of tions in area or fire is or frames in window. Parts 403, 418, 460, 482, 483 details of doors such as angs, automatics closing on and interview, the facility of 47 corridor doors to resident no impediment to closing and or frame and would resist the This deficient practice could ents, staff, and visitors in the sleeping Room 5. Ons with the Maintenance our of the facility from 9:05 on 04/03/23, the corridor door to boom 5 failed to latch into the sted to close multiple times. Inism on the door would not ching plate on the door frame.	K 0363	K363 – It is the intent of the facility to ensure corridor door resident sleeping rooms have impediment to closing and latching into the door frame a would resist the passage of smoke to meet set standards. 1. CORRECTIVE ACTION TAKEN: a. On 4/18/2023 the Maintenance Supervisor/desirepaired the latching mechan in the corridor closet door to resident sleeping room 5 so it latch fully into the frame to me set standards. The Administr verified the repairs on 4/18/202. ALL OTHERS WITH POTENTIAL TO BE AFFECT	e no nd . S gnee ism t eet eator 023.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/03/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD N TIBBS AVE	
WESTPA	RK A WATERS CO	DMMUNITY	INDIA	NAPOLIS, IN 46222	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		corridor door had an		a. All residents and all staf	
	_	ng and latching into the door of tresist the passage of smoke.		and visitors have the potentia	
	frame and would no	of resist the passage of smoke.		be affected but none were. T	
	This finding was re	viewed with the Executive		Maintenance Supervisor/design inspected all corridor doors to	-
		enance Director, and the		ensure they latch fully into the	
	Maintenance Assist			frame and found no other neg	
	conference.	unt during the exit		findings.	alive
				3. MEASURES TO PREVE	NT
	3.1-19(b)			REOCCURRENCE:	
	,			a. On 4/18/2023 the	
				Administrator inserviced the	
				Maintenance Supervisor/design	gnee
				on the requirement that corrid	-
				doors latch fully into the frame	e to
				meet set standards.	
				b. Maintenance	
				Supervisor/designee will inspe	ect
				all corridor doors throughout t	he
				facility monthly to ensure they	'
				latch fully into the frame as a	part
				of the facility's Preventive	
				Maintenance Program and	
				document those inspection re	
				as appropriate. If any issues	
				discovered, they will be addre	
				and resolved immediately. The	
				Maintenance Supervisor/designation	
				will review with the Administrative the inspection results.	iiOi
				c. The Administrator will	
				monitor adherence to the	
				Preventative Maintenance	
				schedule and validate the	
				Preventative Maintenance	
				documentation is in place.	
				4. MONITORING	
				CORRECTIVE ACTION:	
				a. The inspection results w	vill
				be presented by the Maintena	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155389		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/03/2023	
	ROVIDER OR SUPPLIER		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE NAPOLIS, IN 46222	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postriers shall be postrium wall. Smoke in duct penetration systems where are is installed for smoke barriers in the smoke barriers and the smoke barriers are smoked by the smoke barriers and the smoked barriers and the smoke barriers and the smoked barriers are smoked by the smoked barriers and the smoked barriers and the smoked barriers are smoked by the smoked barriers and the smoked barriers are smoked by the smoked barriers and the smoked barriers are smoked by the smoked barriers and the smoked barriers are smoked by the smoked barriers and the smoked barriers are smoked by the smoked barriers and the smoked barriers are smoked by the smoked barriers and the smoked barriers are smoked by the smoked barriers	pall be constructed to a sance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.) hanical smoke control	K 0372	Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/19/2023.	04/19/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/03/2023		
NAME OF I	PROVIDER OR SUPPLIER	• {		ADDRESS, CITY, STATE, ZIP COD	•	
WESTPA	ARK A WATERS CO	DMMUNITY	1316 N TIBBS AVE INDIANAPOLIS, IN 46222			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	_	the smoke barrier. LSC		protected to maintain the fire		
		ection 8.5. Section 8.5.6.2 states		resistance rating of the smoke		
	1 ~	oles, conduits, pipes, and		barrier to meet set standards.		
		ass through a floor/ceiling		1. CORRECTIVE ACTION	8	
	1	ed as a smoke barrier, or		TAKEN:		
		membrane of a ceiling smoke sected by a system or material		a. On 4/18/2023 the	anaa	
		the transfer of smoke. Where		Maintenance Supervisor/desi repaired the hole with a one h	-	
		lso constructed as a fire barrier,		fire rated material that was no		
		all be protected in accordance		in the ceiling of the Janitor's of		
		nts of Section 8.3.5 to limit the		by the west nurse's station ar		
	_	time period equal to the fire		the corridor ceiling outside the	I	
		sembly and Section 8.5.6. This		maintenance director's office		
		ould affect over 10 residents,		the west nurse's station to me	· I	
	staff, and visitors.	,		set standards. The Administr		
	,			verified the repairs on 4/18/20		
	Findings include:			2. ALL OTHERS WITH		
				POTENTIAL TO BE AFFECT	ED:	
	Based on observation	ons with the Maintenance		a. All residents and all state	f I	
	Director and the Ma	aintenance Assistant during a		and visitors have the potentia	l to	
	tour of the facility f	From 9:05 a.m. to 11:20 a.m. on		be affected but none were. C		
	04/03/23, a hole wa	s noted in the ceiling of the		4/18/2023 the Maintenance		
	Janitor's closet by tl	he west nurse's station and in		Supervisor/designee inspecte	ed all	
		outside the Maintenance		ceiling smoke barriers throug	hout	
		the west nurse's station. The		the facility for penetrations an	d	
		vas next to the escutcheon for		found no other negative findir	ngs.	
		l sprinkler at each location.		3. MEASURES TO PREVE	ENT	
	Based on interview			REOCCURRENCE:		
		laintenance Director and the		a. On 4/18/2023 the		
	Maintenance Assist	_		Administrator inserviced the		
		enings did not ensure the		Maintenance Supervisor/desi	-	
	_	er was protected to maintain		on the requirement that ceilin	g	
	the fire resistance ra	ating of the smoke barrier.		smoke barriers must be		
	TE1 ' C' 1'	t dad e		maintained and must be free	of	
	_	viewed with the Executive		penetrations to meet set		
		enance Director, and the		standards.		
	Maintenance Assist	ant during the exit		b. Maintenance		
	conference.			Supervisor/designee will insp	I	
	2 1 10(b)			all ceiling smoke barriers and		
I	3.1-19(b)		I	ensure they are maintained a	na I	

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/03/2023
	ROVIDER OR SUPPLIE		1316 N	ADDRESS, CITY, STATE, ZIP CO I TIBBS AVE NAPOLIS, IN 46222	OD
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE COMPLETION DATE
				free of penetrations as the facility's Preventive Maintenance Program document those inspect as appropriate. If any discovered, they will be and resolved immediate Maintenance Supervisor will review with the Admitherinspection results. c. The Administrator monitor adherence to the Preventative Maintenance Schedule and validate of Constitutes and Schedule at the Quality Assurance/Perfilmprovement (QA/PI) in Inspection results and scomponents will be reverthe QA/PI Committee we subsequent plans of codeveloped and implement deemed necessary to ecompliance is maintain. This plan of correction constitutes our credibule allegation of compliance all regulatory requirem Our date of compliance 4/19/2023.	and ction results issues are addressed ely. The or/designee ministrator r will me nce the nce ce. I: sults will aintenance the and the ent the emonthly formance neeting. system iewed by with orrection ented as ensure ed. In ole ice with nents.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			LETED
		155389	B. WING 04/03/202			/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹			TIBBS AVE		
WESTPA	ARK A WATERS CO	DMMUNITY		INDIANAPOLIS, IN 46222			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0500	NFPA 101						
SS=F	Building Services	- Other					
Bldg. 01	Building Services	- Other					
	List in the REMAF	RKS section any LSC					
	Section 18.5 and	19.5 Building Services					
	requirements that	are not addressed by the					
	provided K-tags, b	out are deficient. This					
	information, along	with the applicable Life					
	Safety Code or NF	FPA standard citation,					
	should be included	d on Form CMS-2567.					
	Based on observation and interview, the facility		K 0500		K500– It is the intent of the facility		04/19/2023
	failed to ensure 4 of	f 5 fuel fired water heaters had			to ensure fuel-fired water heat	ers	
	current inspection c	ertificates to ensure the water			have current inspection certific		
	heaters were in safe operating condition. NFPA				to ensure the water heaters ar		
		.3.1 requires all health facilities			safe operating condition to me		
		tructed, maintained, and			set standards.		
	_	ze the possibility of a fire			1. CORRECTIVE ACTIONS	3	
	-	g the evacuation of occupants.			TAKEN:		
		ice affects all residents, staff,			a. On 4/18/2023 a Certified	I	
	and visitors.				Water Heater Inspector inspec		
					the four fuel fired water heater		
	Findings include:				and provided the facility with		
	C				Certificates of Inspection inclu	dina	
	Based on observation	ons with the Maintenance			1) the service water heater	3	
	Director and the Ma	aintenance Assistant during a			identified as IN321485 2) serv	ice	
		From 9:05 a.m. to 11:20 a.m. on			water heater identified as		
	-	ving four water heaters each			IN321956 3) service water hea	ater	
	had expired Certific	_			identified as IN321957 4) serv		
	-	n the State of Indiana:			water heater identified as		
	a. the service water	heater identified as IN321485.			IN321958 to meet set standard	ds.	
	b. the service water	heater identified as IN321956.			The Administrator verified the		
	c. the service water	heater identified as IN321957.			inspections and receipt of the		
		heater identified as IN321958.			documentation on 4/18/2023 .		
	Based on interview				2. ALL OTHERS WITH		
	observations, the M	faintenance Director stated			POTENTAL TO BE AFFECTE	D:	
		of Inspection documentation			a. All residents and all staff		
		or review and agreed the			and visitors have the potential		
		vice water heaters each had			be affected but none were.	-	
		of Inspection documentation			3. MEASURES TO PREVE	NT	
	from the State of In	-			REOCCURRENCE:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155389	B. W	NG		04/03	/2023
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			TIBBS AVE		
WESTPA	ARK A WATERS CO	YTINUMMC			IAPOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					a. On 4/18/2023 the		
		eviewed with the Executive			Administrator inserviced the		
		tenance Director, and the			Maintenance Supervisor/desig	-	
		tant during the exit			on the requirement that fuel-fi		
	conference.				water heaters must be inspect		
					and a Certificate of Inspection		
	3.1-19(b)				retained at the facility to meet	set	
					standards.		
					b. Maintenance		
					Supervisor/designee will chec		
					fuel-fired water heaters annua		
					ensure they are inspected and		
					documentation retained at the		
					facility as a part of the facility's		
					Preventive Maintenance Prog		
					and document those inspection		
					results as appropriate. If any		
					issues are discovered, they w	ill be	
					addressed and resolved		
					immediately. The Maintenand		
					Supervisor/designee will revie	W	
					with the Administrator the		
					inspection results.		
					c. The Administrator will		
					monitor adherence to the		
					Preventative Maintenance		
					schedule and validate the		
					Preventative Maintenance		1
					documentation is in place.		
					4. MONITORING		1
					CORRECTIVE ACTION:	ill	
					 a. The inspection results w be presented by the Maintena 		
					Supervisor/designee to the	iic c	
					Administrator monthly and the		
					Administrator will present the	•	1
					inspection results at the month	nlv	
					Quality Assurance/Performan	-	
					-		
					Improvement (QA/PI) meeting		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155389	l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/03/2023	
	PROVIDER OR SUPPLIER		13	REET ADDRESS, CITY, STATE, ZIP CO 316 N TIBBS AVE IDIANAPOLIS, IN 46222	OD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) components will be reviewed by the QA/PI Committee with			(X5) COMPLETION DATE	
				subsequent plans of co developed and implement deemed necessary to e compliance is maintain This plan of correction constitutes our credib allegation of compliant all regulatory requiren Our date of compliant 4/19/2023.	orrection ented as ensure ed. n ole nce with nents.		
K 0511 SS=E Bldg. 01	complies with NFI Code, electrical w complies with NFI Code. Existing ins service provided r 18.5.1.1, 19.5.1.1 Based on observation failed to ensure 1 or outlet boxes in the 1 protected and was r Edition. Article 406 (Cover Plates), require installed so as to and seat against the 406.5, states receptalive wiring termina. This deficient pract	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric stallations can continue in no hazard to life.	K 0511	K511 - It is the intent of to ensure wall mounted outlet boxes in the laun room is protected and it to meet set standards. 1. CORRECTIVE ACTAKEN: a. On 4/18/2023 the Maintenance Supervisor installed a new electricand cover plate near the the laundry utilizes room set standards. The Adi	d electrical adry utilities not broken CTIONS bor/designee al outlet te floor in m to meet	04/19/2023	

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Findings include:

Based on observations with the Maintenance

Event ID:

U4J721

Facility ID: 000473

verified the work on 4/18/2023

ALL OTHERS WITH

POTENTIAL TO BE AFFECTED:

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155389		A. BUILDING 01 B. WING		COMPLETED 04/03/2023				
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 1316 N TIBBS AVE INDIANAPOLIS, IN 46222					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	tour of the facility f 04/03/23, the recept outlet box near the f Room was broken is electrical wiring in also not equipped w interview at the time Maintenance Direct broken and the outle cover plate. This finding was re-	antenance Assistant during a rom 9:05 a.m. to 11:20 a.m. on acles in the wall mounted floor in the Laundry Utilizes in half which exposed the the box. The outlet box was rith a cover plate. Based on e of observation, the or agreed the receptacles were et box was not provided with a viewed with the Executive enance Director, and the ant during the exit		a. All residents and all staff and visitors have the potential be affected but none were. Of 4/18/2023 the Maintenance Supervisor/designee inspecte electrical outlets throughout the facility to ensure outlets are not broken and covers are on and found no other negative finding 3. MEASURES TO PREVERECCURRENCE: a. On 4/18/2023 the Administrator inserviced the Maintenance Supervisor/designent that electroutlets are not broken and har properly installed covers to moset standards. b. Maintenance Supervisor/designee will inspect all electrical outlets throughout facility monthly to ensure they not broken and covers are profinstalled as a part of the facility Preventive Maintenance Progund document those inspection results as appropriate. If any issues are discovered, they waddressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	d all he ot l gs. gnee ical ve eet ect the are operly y's ram on ill be			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
155389		B. WING 04			04/03	04/03/2023	
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY				1316 N	ADDRESS, CITY, STATE, ZIP COD TIBBS AVE APOLIS, IN 46222		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
					corrective Action: a. The inspection results we presented by the Maintena Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the month Quality Assurance/Performand Improvement (QA/PI) meeting Inspection results and system components will be reviewed the QA/PI Committee with subsequent plans of correction developed and implemented a deemed necessary to ensure compliance is maintained. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/19/2023.	nnce hlly ce J. by n	
K 0521 SS=F Bldg. 01	comply with 9.2 a accordance with specifications. 18.5.2.1, 19.5.2.1 Based on record reinterview; the facil dampers in the fac provided necessary recent four-year per 90A. LSC 9.2.1 reair conditioning (Fequipment shall be	on, and air conditioning shall and shall be installed in the manufacturer's 1, 9.2 view, observation, and ity failed to ensure all fire allity were inspected and a maintenance within the most eriod in accordance with NFPA requires heating, ventilating and (VAC) ductwork and related in accordance with NFPA 90A, stallation of Air-Conditioning	K 05	521	K521 – It is the intent of the facility to ensure all fire dampe in the facility are inspected an provided necessary maintena at least every four years in accordance with NFPA 90A to meet set standards. 1. CORRECTIVE ACTIONS TAKEN:	d nce	04/19/2023

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Facility ID: 000473

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STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDI		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
155389		B. WING		04/03/2023			
			СТ	DEET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
MEGEDA	DICA MATERIO OC				TIBBS AVE		
WESTPA	RK A WATERS CC	DMMUNITY	IN	DIAN	APOLIS, IN 46222		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)	16	DATE
	and Ventilating Sys	tems. NFPA 90A, 2012			1.On 4/18/2023 a Certifie	d	
		.8.1 states fire dampers shall be			Contractor/designee conducte	d an	
	maintained in accor	dance with NFPA 80, Standard			inspection of the smoke/fire		
		Other Opening Protectives.		dampers in the facility to meet set			
		tion, Section 19.4.1 states each			standards. The Administrator		
		ted and inspected 1 year after			verified the inspection and		
	-	st and inspection frequency			documentation on 4/18/2023		
		rs. If the damper is equipped					
		the link shall be removed for			1.ALL OTHERS WITH		
	· ·	l closure and lock-in-place if			POTENTIAL TO BE AFFECTE	D:	
	_	amper shall not be blocked			1.All residents and all sta		
		way. All inspections and			and visitors have the potential		
	testing shall be documented, indicating the				be affected but none were.		
	location of the fire damper, date of inspection,				2.MEASURES TO PREVENT	Г	
	name of inspector and deficiencies discovered.				REOCCURRENCE:	-	
	The documentation shall have a space to indicate				1.On 4/18/2023 the		
		leficiencies were corrected.			Administrator inserviced the		
		s full unobstructed access to			Maintenance Supervisor/desig	inee	
	the fire damper shall be verified and corrected as				on the requirement that smoke		
	required. This deficient practice could affect all				dampers must be properly	.,	
	residents, staff, and visitors.				inspected and maintained		
	, ,				including inspections at least of	nce	
	Findings include:				every four years to meet set		
	J				standards.		
	Based on record rev	view with the Maintenance			2.Maintenance		
	Director and the Maintenance Assistant from				Supervisor/designee will ensur	re	
		o.m. on 04/03/23, documentation			the smoke/fire dampers are		
	_	ections conducted within the			properly inspected and mainta	ined	
	most recent four-year period was not available for				including an inspection at leas		
		bservations with the	once every four years as a part of				
	Maintenance Director and the Maintenance		the facility's monthly Preventive				
	Assistant during a tour of the facility from 9:05		Maintenance Program and		Č		
	a.m. to 11:20 a.m. on 04/03/23, a fire damper was		document those inspection results				
	installed in HVAC ductwork in the corridor wall		as appropriate. If any issues are				
	outside the Equipment Room near the west		discovered, they will be addressed				
	nurse's station. The fire damper inspection contractor had affixed a sticker to the fire damper				and resolved immediately. Th		
					Maintenance Supervisor/desig		
		recent inspection and			will review with the Administration		
		nce was performed on			the inspection results.		
	-	s more than four years old.			3.The Administrator will		
	07/20/10 WINCH Was	more man rour years ord.	1		J. THE AUTHINSTIATOR WILL		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
155389		B. WIN	B. WING		04/03/2023		
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	1			TIBBS AVE		
WESTPA	RK A WATERS CO	MMI INITY			APOLIS, IN 46222		
WLOTI		DIVINIONI I		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		at the time of record review			monitor adherence to the		
		ons, the Maintenance			Preventative Maintenance		
		damper inspection and			schedule and validate the		
		nentation was not available for			Preventative Maintenance		
	-	locumentation of fire damper			documentation is in place.		
	-	red within the most recent			3.MONITORING CORRECTI	VE	
	four-year period wa	s not available for review.			ACTION:		
	TT1 : 0' 1'				1.The inspection results v		
	_	viewed with the Executive			be presented by the Maintena	nce	
		enance Director, and the			Supervisor/designee to the		
	Maintenance Assist	ant during the exit			Administrator monthly and the		
	conference.				Administrator will present the	- h .	
	2 1 10/b)				inspection results at the month	•	
	3.1-19(b)				Quality Assurance/Performand		
					Improvement (QA/PI) meeting Inspection results and system		
					components will be reviewed by	21/	
					the QA/PI Committee with	у	
					subsequent plans of correction	2	
					developed and implemented a		
					deemed necessary to ensure	3	
					compliance is maintained.		
					This plan of correction		
					constitutes our credible		
					allegation of compliance with	1	
					all regulatory requirements.	-	
					Our date of compliance is		
				4/19/2023.			
K 0930	NFPA 101						
SS=A		Liguid Oxygen Equipment					
Bldg. 01		Liquid Oxygen Equipment					
		ise of liquid oxygen in base					
		rs and portable containers					
		ons 11.7.2 through 11.7.4					
	(NFPA 99).						
	11.7 (NFPA 99)						
		on and interview, the facility	K 09	30	K930– It is the intent of the fac	ility	04/19/2023
	-	f 47 resident rooms from the			to ensure to protect resident		
	use of liquid oxyger	n containers stored in a patient			rooms from the use of liquid		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 COMPLETED 155389 B. WING 04/03/2023	
155389 B. WING 04/03/2023	
CTREET ADDRESS CITY STATE ZID COD	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD	
1316 N TIBBS AVE	
WESTPARK A WATERS COMMUNITY INDIANAPOLIS, IN 46222	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS READ OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	N
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
bed location or patient care room. NFPA 99, oxygen containers stored in a	
Health Care Facilities Code, 2012 Edition, Section patient bed location or patient care	
11.7.4 states the maximum total quantity of liquid room to meet set standards.	
oxygen permitted in storage and in use in a patient 1. CORRECTIVE ACTIONS	
bed location or patient care room shall be 120 L TAKEN:	
(31.6 gallons), provided that the patient bed a. On 4/18/2023 the Director of	
location or patient care room, or both, are Nursing/designee removed the one	
separated from the remainder of the facility by fire liquid oxygen container that was	
barriers and horizontal assemblies having a stored in resident sleeping room 7	
minimum fire resistance rating of 1 hour in to meet set standards. The	
accordance with the adopted building code. Per Administrator verified the work on	
Centers for Medicare & Medicaid Services (CMS), 4/18/2023.	
2012 Edition, Section 11.7.4, but NFPA has POTENTIAL TO BE AFFECTED:	
released a Tentative Interim Amendment (TIA) for a. All residents and all staff	
that section and CMS will be issuing further and visitors have the potential to	
guidance on that code section. LSC Section be affected but none were. On	
7.2.4.3.10 requires all fire door assemblies in 4/18/2023 Director of	
horizontal exits shall be self-closing or automatic Nursing/designee checked all	
closing. This deficient practice could affect over 1 areas of the facility for improperly	
resident, staff, and visitors in the vicinity of Room stored oxygen containers and	
7. found no other negative findings.	
3. MEASURES TO PREVENT	
Findings include: REOCCURRENCE:	
a. On 4/18/2023 the	
Based on observations with the Maintenance Administrator inserviced the	
Assistant during a tour of the facility from 9:05 Director of Nursing and all other	
a.m. to 11:20 a.m. on 04/03/23, one liquid oxygen nursing staff on the requirement	
container was stored in resident sleeping Room 7. that oxygen containers must be in	
Room 7 was not separated from the remainder of the proper storage areas to meet	
the facility by fire barriers and horizontal set standards.	
assemblies having a minimum fire resistance rating b. Director of Nursing/designee	
of 1 hour. The corridor door to the room was not will inspect all oxygen containers	
self-closing or automatic closing and was not throughout the facility weekly to	
equipped with a minimum 45-minute fire resistance ensure they are properly stored as	
rating label affixed to the door. Based on a part of the facility's oxygen	
interview at the time of the observations, the handling Program and document	
Maintenance Assistant agreed one liquid oxygen those inspection results as	
container was stored in Room 7 and the room was appropriate. If any issues are	
not maintained with a minimum fire resistance discovered, they will be addressed	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
155389		B. WING		04/03/2023		
NAME OF PROVIDER OR SUPPLIER WESTPARK A WATERS COMMUNITY		1316 N	ADDRESS, CITY, STATE, ZIP COD I TIBBS AVE NAPOLIS, IN 46222			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF rating of 1 hour. This finding was re	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION viewed with the Executive enance Director, and the			will the /gen the vill of r will at g. n by	
				allegation of compliance with all regulatory requirements. Our date of compliance is 4/19/2023.		

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