STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155135	A. BUILDING -- B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTVIEW NURSING AND REHABILITATION CENTER	1510 CLINIC DR BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/17/22 Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600 At this Emergency Preparedness survey, Westview Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 95 certified beds. At the time of the survey, the census was 68. Quality Review completed on 11/21/22	E 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully request that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/17/22 Facility Number: 000060 Provider Number: 155135 AIM Number: 100266600 At this Life Safety Code survey, Westview	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully request that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melody Sowders	Executive Director	12/05/2022

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	Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Resident sleeping rooms in Cottage Hall are provided with smoke detectors hard wired to the fire alarm system. Battery operated smoke alarms are installed in all other resident sleeping rooms. The facility has a capacity of 95 and had a census of 68 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility has one detached storage building which was not sprinklered. Quality Review completed on 11/21/22			
K 0100 SS=B Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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 ensure 1 of 4 corridor door sets would self close and latch into the door frame per	K 0100	1.) **What corrective action(s) will be accomplished for those residents found to have been**	12/05/2022

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	4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the corridor door set by Therapy. Findings include: Based on observations with the Environmental Services Director and Field Supervisor during a tour of the facility from 12:37 p.m. to 1:45 p.m. on 11/17/22, the corridor door set by by Therapy were held in the fully open position with a magnetic hold open devices set to release with fire alarm system activation, latching hardware and a self closing device but the doors failed to self close and latch into the door frame when tested to close multiple times. The bottom of the west door kept dragging on the floor, slowing it down just enough so that it would not latch into the door frame. Based on interview at the time of the observation, the Environmental Services Director agreed the south door in the door set would not fully self close and latch into the door frame. The Field Supervisor adjusted the door so that it self closed and latched into the door frame prior to suvey exit. This finding was reviewed with the Executive Director, Enrironmental Services Director and Field Supervisor during the exit conference. 3.1-19(b)		**affected by the deficient practice?** On November 17, 2022, the Field Supervisor re-aligned door until it closed efficiently, this was completed prior to survey exit. **2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Residents, staff and/or visitors in the vicinity of the corridor door set by therapy have the potential to be affected by the alleged deficient practice. Environmental Director and the Maintenance Assistant checked all self-closing doors to verify doors in facility were correctly latching. **3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Executive Director conducted an in-service with Environmental Director, Maintenance Assistant, and floor tech regarding inspection of proper closure of the corridor door set. **4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?**	

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			The Environmental Director/designee will monitor self-closing doors, weekly times 4 weeks, monthly times 6 months, and quarterly times 2. Any concerns will be brought to the QAPI committee for review.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces			

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	(over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice is not in a resident care area and could affect staff in the vicinity of the laundry room. Findings include: Based on observation with the Environmental Services Director and Field Supervisor during a tour of the facility from 12:37 p.m. to 1:45 p.m. on 11/17/22, the corridor door to the Laundry room in the service hall which contained fuel-fired dryers was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. When the door reached the door frame, the top of the door hit the door frame, not allowing it to self close without pulling on the handle and closing it with some force. Based on interview at the time of observation, the Field Supervisor agreed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame and stated the frame appears to be loose on the hinge side and would need to be worked on. This finding was reviewed with the Executive Director, Environmental Services Director and Field Supervisor at the exit conference. 3.1-19(b)	K 0321	1.) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 11/17/22, the Field Supervisor realigned Laundry door until it closed efficiently. **2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All staff in the vicinity of the Laundry room have the potential to be affected by the alleged deficient practice. On November 17, 2022, the Environmental Director and Maintenance Assistant checked all self-closing doors to verify doors in facility were correctly latching. **3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Executive Director conducted an in-service with Environmental Director, Maintenance Assistant, and floor tech regarding inspection of proper closure of laundry door. **4.) How the corrective action**	12/05/2022

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			will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? The Environmental Director/designee will monitor self-closing doors, weekly times 4 weeks, monthly times 6 months, and quarterly times 2. Any concerns will be brought to the QAPI committee for review.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 set of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly functioning coordinator to ensure the door which must close first always closes first. This deficient practice could affect more than 25 residents, as well as staff and visitors in Visions Hall and the main dining room.	K 0374	1.) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 11/17/22, the Environmental Director and Maintenance Assistant realigned smoke barrier door until it closed efficiently.	12/05/2022

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	Findings include: Based on observation on 11/17/22 at 1:35 p.m. during a tour of the facility with the Environmental Services Director and Field Supervisor, the set of smoke barrier doors between main dining room and the Resident room 56 in the Visions Hall closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the door frame, however, it did not function correctly when tested because it did not stop the door with the astragal from closing first. When tested, the doors did not latch into the door frame due to the faulty coordinator. Based on interview at the time of observation, the Environmental Services Director agreed the coordinator did not allow the set of smoke barrier doors to function as designed. This finding was reviewed with the Executive Director, Environmental Services Director and Field Supervisor during the exit conference. 3.1-19(b)		**2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents living on the Visions Unit or are in the main dining room have the potential to be affected by the alleged deficient practice. On November 17, 2022, the Environmental Director and Maintenance Assistant checked all self-closing doors to verify doors in facility were correctly latching. **3.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Executive Director conducted an in-service with Environmental Director, Maintenance Assistant, and floor tech regarding inspection of proper closure of smoke barrier doors. **4.) How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The Environmental Director/designee will monitor self-closing doors, weekly times 4 weeks, monthly times 6 months, and quarterly times 2. Any concerns will be brought to the	

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			QAPI committee for review.	