PRINTED: 12/07/2022 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OM	1B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155135	B. WING		11/17	/2022	
NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1510 CLINIC DR BEDFORD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	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		K 0000	The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion see in the statement of deficience of any violation of regulation. This provider respectfully received that this 2567 Plan of Correct be considered the Letter of Credible Allegation of Compliand requests a desk review in	not nis et forth ies, or quest tion		
	At this Life Safety Code survey, Westview		1	of a post survey review.		I	

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

(X6) DATE

TITLE

Melody Sowders **Executive Director** 12/05/2022

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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/17/2022				
NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER			1510 C	STREET ADDRESS, CITY, STATE, ZIP COD 1510 CLINIC DR BEDFORD, IN 47421				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	in compliance with in Medicare/Medica Life Safety from Fin National Fire Protec Life Safety Code (L Health Care Occupa	Requirements for Participation aid, 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.						
	determined to be of was fully sprinklere system with smoke spaces open to the c rooms in Cottage H detectors hard wired Battery operated sm other resident sleep	ty with a partial basement was Type V (000) construction and d. The facility has a fire alarm detection in the corridors and corridors. Resident sleeping all are provided with smoke d to the fire alarm system. The facility has a mad a census of 68 at the time						
	access were sprinkle detached storage bu sprinklered.	residents have customary ered. The facility has one ilding which was not						
K 0100 SS=B 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.						
	failed to ensure 1 of	on and interview, the facility 4 corridor door sets would into the door frame per	K 0100	1.) What corrective action(s will be accomplished for the residents found to have been	se			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 11/17/2022 155135 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1510 CLINIC DR WESTVIEW NURSING AND REHABILITATION CENTER BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 4.6.12.3. LSC 4.6.12.3 requires existing life safety affected by the deficient features obvious to the public if not required by practice? the Code, shall be either maintained or removed. On November 17, 2022, the Field This deficient practice could affect over 5 Supervisor re-aligned door until it residents, staff and visitors in the vicinity of the closed efficiently, this was corridor door set by Therapy. completed prior to survey exit. Findings include: 2.) How other residents having the potential to be Based on observations with the Environmental affected by the same deficient Services Director and Field Supervisor during a practice will be identified and tour of the facility from 12:37 p.m. to 1:45 p.m. on what corrective action(s) will 11/17/22, the corridor door set by by Therapy be taken; were held in the fully open position with a Residents, staff and/or visitors in magnetic hold open devices set to release with fire the vicinity of the corridor door set alarm system activation, latching hardware and a by therapy have the potential to be self closing device but the doors failed to self affected by the alleged deficient close and latch into the door frame when tested to practice. Environmental Director close multiple times. The bottom of the west door and the Maintenance Assistant kept dragging on the floor, slowing it down just checked all self-closing doors to enough so that it would not latch into the door verify doors in facility were frame. Based on interview at the time of the correctly latching. observation, the Environmental Services Director agreed the south door in the door set would not 3.) What measures will be put fully self close and latch into the door frame. The into place or what systemic Field Supervisor adjusted the door so that it self changes will be made to closed and latched into the door frame prior to ensure that the deficient suvey exit. practice does not recur? The Executive Director conducted This finding was reviewed with the Executive an in-service with Environmental Director, Enrironmental Services Director and Director, Maintenance Assistant, Field Supervisor during the exit conference. and floor tech regarding inspection of proper closure of the corridor 3.1-19(b) door set.

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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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING			
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
WESTVI	EW NURSING AND	REHABILITATION CENTER		CLINIC DR DRD, IN 47421	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				The Environmental Director/designee will moni self-closing doors, weekly t weeks, monthly times 6 mo and quarterly times 2. Any concerns will be brought to QAPI committee for review	imes 4 inths, the
K 0321	NFPA 101				
SS=E	Hazardous Areas	- Enclosure			
Bldg. 01	Hazardous Areas				
	Hazardous areas	are protected by a fire			
	_	our fire resistance rating			
		rated doors) or an			
		nguishing system in			
		3.7.1 or 19.3.5.9. When the tic fire extinguishing system			
		e areas shall be separated			
		by smoke resisting			
		rs in accordance with 8.4.			
	Doors shall be sel				
		and permitted to have			
		applied protective plates that inches from the bottom of			
	the door.	inches from the bottom of			
		and zone locations of			
	hazardous areas t	that are deficient in			
	REMARKS.				
	19.3.2.1, 19.3.5.9				
	Area	Automatic Sprinkler			
		N/A			
		-Fired Heater Rooms			
	b. Laundries (large	er than 100 square feet)			
		nance, and Paint Shops			
		ooms (exceeding 64			
	gallons)	_			
	e. Trash Collection				
	(exceeding 64 gal	•			
	i. Combustible Sto	orage Rooms/Spaces	1	Ī	

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155135		1	A. BUILDING <u>01</u> B. WING		COMPLETED 11/17/2022			
		100100	<i>D.</i> 17 IN			1 1/1//	2022	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD LINIC DR			
WESTVII	EW NURSING AND	REHABILITATION CENTER			PRD, IN 47421			
(X4) ID	4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	(over 50 square fe	eet)						
	g. Laboratories (if	classified as Severe						
	Hazard - see K32	•						
		on and interview, the facility	K 03	21	1.) What corrective action(-	12/05/2022	
		f 1 laundry rooms were			will be accomplished for tho			
		er spaces by smoke resistant			residents found to have bee	n		
	_	s. Doors shall be self-closing			affected by the deficient			
	1	g in accordance with LSC			practice?	ioor		
	7.2.1.8. This deficient practice is not in a resident care area and could affect staff in the vicinity of				On 11/17/22, the Field Supervice realigned Laundry door until it			
	the laundry room.	arreet starr in the vicinity or			closed efficiently.			
	the faultary room.				Glosed emolerity.			
	Findings include:				2.) How other residents			
	_				having the potential to be			
	Based on observation	on with the Environmental			affected by the same deficie	nt		
	Services Director as	nd Field Supervisor during a			practice will be identified an	d		
	1	from 12:37 p.m. to 1:45 p.m. on			what corrective action(s) wil	I		
		or door to the Laundry room in			be taken;			
		ch contained fuel-fired dryers			All staff in the vicinity of the			
		a self-closing device but the			Laundry room have the poten			
	I -	close and latch into the door			be affected by the alleged def			
		hree separate times. When the or frame, the top of the door			practice. On November 17, 2 the Environmental Director ar			
		not allowing it to self close			Maintenance Assistant check			
		the handle and closing it with			all self-closing doors to verify	Ju		
		on interview at the time of			doors in facility were correctly			
		eld Supervisor agreed the			latching.			
		aforementioned hazardous						
	area failed to self-cl	lose and latch into the door			3.) What measures will be	put		
		e frame appears to be loose on			into place or what systemic			
	the hinge side and v	vould need to be worked on.			changes will be made to			
					ensure that the deficient			
	_	viewed with the Executive			practice does not recur?			
		ental Services Director and			The Executive Director condu			
	Field Supervisor at	the exit conference.			an in-service with Environmer			
	2.1.10/1->				Director, Maintenance Assista			
	3.1-19(b)				and floor tech regarding inspe			
				of proper closure of laundry d	oor.			

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4.) How the corrective action

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155135	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 11/17/2022	
NAME OF PROVIDER OR SUPPLIER								
WESTVIEW NURSING AND REHABILITATION CENTER				BEDFC	ORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE TAG DEFICIENCY)		ATE	(X5) COMPLETION DATE	
					will be monitored to ensure deficient practice will not reci.e. what quality assurance program will be put into place. The Environmental Director/designee will monitor self-closing doors, weekly tim weeks, monthly times 6 month and quarterly times 2. Any concerns will be brought to the QAPI committee for review.	cur ce? es 4 hs,		
K 0374 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Doors 2012 EXISTING Doors in smoke be solid bonded wood construction that r Nonrated protectiv are permitted. Doo fixed fire window a are self-closing or require latching, a in the direction of	esists fire for 20 minutes. We plates of unlimited height ors are permitted to have assemblies per 8.5. Doors automatic-closing, do not are not required to swing egress travel. Door opening am clear width of 32 inches rizontal doors.						
	Based on observation failed to ensure 1 of which swing in the with an astragal have coordinator to ensure	on and interview, the facility 1 set of smoke barrier doors same direction and equipped re a properly functioning re the door which must close first. This deficient practice	K 0	374	1.) What corrective action(will be accomplished for the residents found to have bee affected by the deficient practice? On 11/17/22, the Environmen	ose n	12/05/2022	

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dining room.

could affect more than 25 residents, as well as

staff and visitors in Visions Hall and the main

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Director and Maintenance

door until it closed efficiently.

Assistant realigned smoke barrier

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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> CC		COMPL	COMPLETED	
155135		155135	B. WING		11/17/	2022	
NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1510 CLINIC DR BEDFORD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	VIE	DATE	
IAU	Based on observation during a tour of the Services Director a smoke barrier door and the Resident roclosed in the same attached to one of the coordinator attached it did not function of it did not stop the declosing first. When into the door frame Based on interview Environmental Services and the coordinator did not doors to function as This finding was reduced.	on on 11/17/22 at 1:35 p.m. If acility with the Environmental and Field Supervisor, the set of set between main dining room from 56 in the Visions Hall direction with an astragal the doors. There was a door do to the door frame, however, correctly when tested because floor with the astragal from tested, the doors did not latch to due to the faulty coordinator. Fat the time of observation, the vices Director agreed the allow the set of smoke barrier	IAG	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 Vision Unit or are in the main dining thave the potential to be affect by the alleged deficient practice on November 17, 2022, the Environmental Director and Maintenance Assistant checker all self-closing doors to verify doors in facility were correctly latching. 3.) What measures will be printed in the interior of the Executive Director conducts an in-service with Environment Director, Maintenance Assistant and floor tech regarding inspection of proper closure of smoke based doors. 4.) How the corrective action will be monitored to ensure the ensure that the deficient practice will not receive. What quality assurance program will be put into place the Environmental Director/designee will monitor self-closing doors, weekly time weeks, monthly times 6 month and quarterly times 2. Any	d I ons room ed ce. ed otal int, ection interesting the cur ce?	DATE	

concerns will be brought to the

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155135	X2) MULTIPLE CONSTRUCTION A. BUILDING D1 B. WING		(X3) DATE SURVEY COMPLETED 11/17/2022		
NAME OF PROVIDER OR SUPPLIER WESTVIEW NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 1510 CLINIC DR BEDFORD, IN 47421			
(X4) ID PREFIX	PROVIDER'S PLAN OF CORRECTION				(X5) COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION	PREFIX (EACH CORRECTIVE ACTION SHOULD BE: CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE	
			QAPI committee for review.				
			I				I

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