STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(V2) MIII TIBLE C	X3) DATE SURVEY		
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	JIN ST KUCTIUN	· ′	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155606	B. WING		02/10/2025	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				/ 10TH ST		
WESTSI	DE RETIREMENT \	/ILLAGE	INDIAN	IAPOLIS, IN 46234		
(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	
E 0000						
51.1						
Bldg	4 E B	1 0	F 0000			
		paredness Survey was	E 0000			
accordance with 42		diana Department of Health in				
	accordance with 42	CTR 403.73.				
	Survey Date: 02/10	/25				
	Facility Number: 0	00497				
	Provider Number:	155606				
	AIM Number: 100	291530				
		Preparedness survey,				
		nt Village was found in				
	_	nce with Emergency irements for Medicare and				
		rements for Medicare and Signature and Signature and Signature 42				
	CFR 483.73.	ing Froviders and Suppliers, 42				
	C1103.73.					
	The facility has 132	2 certified beds. At the time of				
	the survey, the cens					
	Quality Review cor	npleted on 02/12/25				
	-	42 CFR, Subpart 483.73 is NOT				
	MET as evidenced	by:				
E 0039	402 749(4)(2) 444	S E4(d)(2), 419 112(d)(
SS=C	EP Testing Requi	6.54(d)(2), 418.113(d)(
Bldg	Li resting requi	rements				
· - · · · · · · · · · · · · · · · ·	Based on record rev	view and interview, the facility	E 0039	K039	03/03/2025	
		exercises which tested the	E 0037	What corrective action will b		
	emergency plan at l	east twice per year, including		accomplished for those		
	unannounced staff	drills using the emergency		residents found to have been	1	
	procedures. The LT	C facility must do the		affected by the alleged		
	following:			deficient practice?		
	• •	annual full-scale exercise that		The after-action reports have	been	
	is community-based			completed for 12/24/24 and		
	a. When a commun	ity-based exercise is not		10/31/24 of the table top		

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

TITLE (X6) DATE

Maurice Woolfolk Executive Director 02/24/2025

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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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	ETED
		155606	B. W	NG		02/10/	2025
				_	_		
NAME OF 1	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
=====					/ 10TH ST		
WESTSI	DE RETIREMENT \	/ILLAGE		INDIAN	IAPOLIS, IN 46234		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	accessible, conduct	an annual individual,			exercises.		
	facility-based funct				How other residents having	the	
	•	y experiences an actual natural			potential to be affected by th		
		gency that requires activation			same deficient practice will		
	1	lan, the LTC facility is exempt			identified and what corrective		
		ext required full-scale			action will be taken:		
		or individual, facility-based			Current maintenance director	was	
	1	l exercise for 1 year following			provided education regarding		
	the onset of the actu	,			completion of after-action rep		
		itional exercise that may			completion.	JIL	
	` '	imited to the following:			What measures will be put in	ato	
	a. A second full-sca	_			place or what systemic	ito	
		or an individual, facility-based			changes will be made to		
	functional exercise.	-			ensure that the deficient		
	b. A mock disaster				practice does not recur:		
		se or workshop that is led by a			The Administrator /designee will		
	_	des a group discussion, using					
		y-relevant emergency scenario,			be responsible to review mon 6 months that after action rep	-	
	1	n statements, directed			· ·	OIL	
	_	red questions designed to			has been completed and the		
	challenge an emerg	-			documentation is in the		
		CC facility's response to and			emergency management plan binder.	l	
		ation of all drills, tabletop			How the corrective action wi	:11	
		gency events, and revise the				III	
					be monitored to ensure the		
	1	gency plan, as needed in CFR 483.73(d)(2). This			deficient practice will not		
					recur:	مطالك	
	deficient practice co	ould affect all occupants.			The results of these reviews v		
	Findings include:				discussed at the monthly facil	-	
	rindings include.				Quality Assurance Committee		
	D1	#E			meeting monthly for three mo		
		"Emergency Management on with the Executive Director			and then quarterly for a total of		
					months. Re-education, freque	-	
		irector during record review			and/or duration of reviews will		
		2:20 p.m. on 02/10/25,			increased as needed if any ar		
		a facility based drill and			of noncompliance are identified		
	^	at challenged the emergency			during the auditing process ur		
	_	st recent year period was			compliance has been reached	i.	
	_	nentation for a tabletop exercise			Date of Compliance: 3/3/25		
	conducted on 12/27	/24 and a facility based					

exercise conducted on 10/31/24 did not include an

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER 155606		JILDING		COMPLETED 02/10/2025		
	PROVIDER OR SUPPLIER DE RETIREMENT V		STREET ADDRESS, CITY, STATE, ZIP COD 8616 W 10TH ST INDIANAPOLIS, IN 46234					
(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)	TE	(X5) COMPLETION DATE	
	of record review, the that after action reports exercises were not a of the survey.	Based on interview at the time e Maintenance Director agreed ort documentation for the two available for review at the time viewed with the Executive enance Director during the exit						
K 0000							1	
Bldg. 03	Licensure Survey w Department of Heal 483.90(a). Survey Date: 02/10/ Facility Number: 02/10/ Provider Number: 1002 At this Life Safety C Retirement Village with Requirements of Medicare/Medicaid, Life Safety from Fin National Fire Protect Life Safety Code (L) Health Care Occupation on the corridor. The facility has a find detection in the corridor. The facility has a find smoke detectors instituted to the same of the corridor. The facility has a find the corridor of the corridor. The facility has a find the corridor of the cor	00497 155606 291530 Code survey, Westside was found not in compliance	K 0	000				

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` ´		` ′				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 03 COMI			
		155606	B. WII	NG		02/10/	2025
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 8616 W 10TH ST INDIANAPOLIS, IN 46234			
(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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0291	access were sprinkle provide facility serv Quality Review con NFPA 101	residents have customary ered and all areas which rices were sprinklered. npleted on 02/12/25					
SS=C Bldg. 03	Emergency Lighting		K 02	291	K291 What corrective action will b accomplished for those residents found to have been affected by the alleged deficient practice? The battery powered 30 secon emergency light tests have be completed and documented. How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Current maintenance director provided education regarding completion of emergency light tests.	nd en the e be e was the	03/03/2025
	for inspection by the jurisdiction. This dependents, as well as facility. Findings include: Based on record revewith the Maintenant facility's preventative.	s shall be kept by the owner e authority having eficient practice could affect all staff and visitors in the riew on 02/10/25 at 1:33 p.m. the Director present, the we maintenance report to powered emergency light			What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator /designee who be responsible to review mont 6 months that battery powered emergency light tests are completed and the documentaris in the TELS system.	vill hly x i	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155606	B. Wl	NG		02/10/	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	2			10TH ST		
WESTSI	DE RETIREMENT \	/ILLAGE		INDIANAPOLIS, IN 46234			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		onthly for 30 seconds,			How the corrective action wi	il.	
		e no 30 second tests performed			be monitored to ensure the		
	in August of 2024. Based on an interview at the				deficient practice will not		
		ew, the Maintenance Director			recur:		
		o monthly 30 second tests			The results of these reviews w		
	performed during A				discussed at the monthly facili	-	
	Maintenance staffin	ng issues.			Quality Assurance Committee		
		· · · · · · · · · · · · · · · · · · ·			meeting monthly for three mor		
		viewed with the Executive			and then quarterly for a total o		
		enance Director during the exit			months. Re-education, freque	-	
	conference.				and/or duration of reviews will		
	2 1 10/1				increased as needed if any are		
	3.1-19(b)				of noncompliance are identifie		
					during the auditing process un		
					compliance has been reached	•	
					Date of Compliance: 3/3/25		
K 0300	NFPA 101						
SS=C	Protection - Other						
Bldg. 03							
9	Based on record rev	view, interview, and	K 0	300	K300		03/03/2025
		ility failed to ensure	110.	300	What corrective action will be	е	03/03/2023
		the preventative maintenance			accomplished for those		
		ted smoke alarms in resident			residents found to have beer	1	
		e. NFPA 101 in 4.6.12.3 states			affected by the alleged		
		features obvious to the public,			deficient practice?		
	if not required by th	ne Code, shall be maintained.			Battery-operated smoke detec	tors	
	NFPA 72, 29.10 Ma	aintenance and Tests.			in resident rooms were inspec		
	Fire-warning equip	ment shall be maintained and			and documented.		
	tested in accordance	e with the manufacturer's			How other residents having t	he	
	published instruction	ons and per the requirements			potential to be affected by th	е	
	of Chapter 14. NFP	A 72, 14.2.1.1.1 Inspection,			same deficient practice will b	e	
	-	nance programs shall satisfy			identified and what correctiv	е	
	_	this Code and conform to the			action will be taken:		
	equipment manufac	eturer's published instructions.			Current maintenance director	was	
	This deficient pract	ice could affect all residents,			provided education regarding	the	
	staff, and visitors.				inspection and documentation		
					battery-operated smoke detec	tors	
	Findings include:				in resident rooms.		
			1		What measures will be put in	ito	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155606		A. BUILDING <u>03</u> COMPI			(X3) DATE : COMPL 02/10/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8616 W 10TH ST INDIANAPOLIS, IN 46234				
(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 APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
	Maintenance Direct 02/10/25 between 1 preventative mainte resident room batter not available for the 8/17/24 and 9/28/24 of review, the Main other documentation detector testing was survey. During the toperated smoke determined to the company of the survey. This finding was revented to the company of the survey.	view and observation with the or and Executive Director on 0:40 a.m. and 2:20 p.m., nance documentation of ry operated smoke alarms was a weeks of 8/3/24, 8/10/24, b. Based on interview at the time tenance Director stated no in for battery operated smoke available at the time of the facility, battery ectors were observed in the oms. Viewed with the Executive enance Director at the exit			place or what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator /designee who e responsible to review month 6 months that battery-operated smoke detectors in resident rooms have been inspected, documented and put in the TE system. How the corrective action will be monitored to ensure the deficient practice will not recur: The results of these reviews which discussed at the monthly facility Quality Assurance Committee meeting monthly for three monand then quarterly for a total or months. Re-education, frequer and/or duration of reviews will increased as needed if any are of noncompliance are identified during the auditing process un compliance has been reached Date of Compliance: 3/3/25	nly x I LS I ill be y ths f 6 ncy be eas d til	
K 0351 SS=E Bldg. 03	NFPA 101 Sprinkler System -	- Installation					
	failed to maintain the facility in accordance the Installation of Section 2010 edition, Section escutcheons, or other annular space around or shall be listed for	on and interview, the facility the ceiling construction in the the with NFPA 13, Standard for prinkler Systems. NFPA 13, on 6.2.7.1 states plates, therefore devices used to cover the d a sprinkler shall be metallic, the use around a sprinkler. This bould affect staff, visitors and	K 0:	351	What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident room 111 bathroom a dry goods storage room in the kitchen were identified as havi	and	03/03/2025
M CMS-2567(02	2-99) Previous Versions Ob	solete Event ID: ZF	VR21	Facility I	D: 000497 If continuation sh	eet Pag	ge 6 of 15

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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 COMPLETED 03 B. WING 02/10/2025 155606 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8616 W 10TH ST WESTSIDE RETIREMENT VILLAGE INDIANAPOLIS, IN 46234 (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 up to 30 residents in two smoke compartments. missing sprinkler escutcheons. Fire sprinkler contractor was Findings include: notified, and escutcheons have been ordered for installation. Based on observation with the Executive Director How other residents having the and Maintenance Maintenance Director on potential to be affected by the 02/10/25 during a tour of the facility at 2:55 p.m., same deficient practice will be the bathroom in resident room 111 had a missing identified and what corrective sprinkler escutcheon. Additionally, the sprinkler action will be taken: located in a dry goods storage room in the kitchen Current maintenance director was was missing an escutcheon. Based on interview at provided education regarding the the time of each observation, the Maintenance inspection of fire sprinkler Director confirmed the escutcheons were missing. escutcheons. What measures will be put into This finding was reviewed with the Executive place or what systemic Director and Maintenance Director at the exit changes will be made to conference. ensure that the deficient practice does not recur: 3.1-19(b) The Administrator /designee will be responsible to review monthly x 6 months that fire sprinkler escutcheons are present. How the corrective action will be monitored to ensure the deficient practice will not recur: The results of these reviews will be discussed at the monthly facility **Quality Assurance Committee** meeting monthly for three months and then quarterly for a total of 6 months. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached. Date of Compliance: 3/3/25

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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 COMPLETED 03 B. WING 02/10/2025 155606 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8616 W 10TH ST WESTSIDE RETIREMENT VILLAGE INDIANAPOLIS, IN 46234 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0353 **NFPA 101** SS=F Sprinkler System - Maintenance and Testing Bldg. 03 1. Based on record review and interview, the K 0353 K0353 03/03/2025 facility failed to document sprinkler system What corrective action will be inspections in accordance with NFPA 25. NFPA accomplished for those 25, Standard for the Inspection, Testing, and residents found to have been Maintenance of Water-Based Fire Protection affected by the alleged Systems, 2011 Edition, Section 5.2.4.1 states deficient practice? gauges on wet pipe sprinkler systems shall be Sprinkler system gauge and inspected monthly to ensure that they are in good control valve checks have been condition and that normal water supply pressure completed and documented. The is being maintained. Section 5.1.2 states valves sprinkler heads in the laundry and fire department connections shall be room have been cleared of lint. inspected, tested, and maintained in accordance Sprinkler heads have been with Chapter 13. Section 13.1.1.2 states Table inspected to ensure no lint or 13.1.1.2 shall be utilized for inspection, testing and debris is present. maintenance of valves, valve components and How other residents having the trim. Section 4.3.1 states records shall be made for potential to be affected by the all inspections, tests, and maintenance of the same deficient practice will be system and its components and shall be made identified and what corrective available to the authority having jurisdiction upon action will be taken: request. This deficient practice could affect all Current maintenance director was residents, staff, and visitors. provided education regarding fire equipment maintenance and Findings include: inspection of the sprinkler gauges and valves. Based on review of sprinkler gauge and control What measures will be put into valve documentation for the most recent twelve place or what systemic month period with the Maintenance Director changes will be made to during record review from 10:40 a.m. to 2:20 p.m. ensure that the deficient on 02/10/25, monthly wet sprinkler system gauge practice does not recur: and control valve inspection documentation for The Administrator /designee will three of the most recent 12 month period was also be responsible to review monthly x not available for review. The months of July, 6 months that the sprinkler August and September 2024 were not available. system gauge and control valve Based on interview at the time of record review, check has been completed, and the Maintenance Director confirmed that sprinkler the documentation has been system gauge and control valve inspection uploaded into the TELS system.

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documentation for the aforementioned monthly

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Also, fire sprinkler heads will be

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ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155606	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>03</u>	(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIE		8616 V	ADDRESS, CITY, STATE, ZIP COD V 10TH ST NAPOLIS, IN 46234		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
IAG	periods was not available periods was not available periods. 2. Based on observer failed to ensure the washing machine a covered with lint waccordance with Nathe Inspection, Tes Water-Based Fire I Edition, Section 5.2 show signs of leakar foreign materials, period periods and periods are periods and peri	ation and interview; the facility ee sprinkler heads in the trea of the Laundry room were replaced or cleaned in FPA 25. NFPA 25, Standard for ting, and Maintenance of Protection Systems, 2011 2.1.1.1 states sprinklers shall not tage; shall be free of corrosion, to be interested on the correct orientation (e.g., or sidewall). Furthermore, at kler that shows signs of any of be replaced:	IAG	inspected x 6 months to ensus sprinklers are free of lint or deposition of the monitored to ensure the deficient practice will not recur: The results of these reviews discussed at the monthly fact Quality Assurance Committed meeting monthly for three meand then quarterly for a total months. Re-education, frequi and/or duration of reviews with increased as needed if any a of noncompliance are identified during the auditing process to compliance has been reached Date of Compliance: 3/3/25	ebris. vill be ility e onths of 6 ency Il be reas ed intil d.	DATE
	i maniga menade.					

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Based on observation with the Maintenance Director and Executive Director during a tour of the facility at 3:05 p.m. on 02/10/25, three

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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 03 155606 B. WING 02/10/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8616 W 10TH ST WESTSIDE RETIREMENT VILLAGE INDIANAPOLIS, IN 46234 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE sprinklers located at the washing machines in the Laundry room were covered with lint. Based on interview at the time of observation, the Maintenance Director agreed that the three automatic sprinklers were loaded with lint. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)K 0355 **NFPA 101** SS=E Portable Fire Extinguishers Bldg. 03 Based on observation and interview, the facility K 0355 K0355 03/03/2025 failed to ensure 2 of 35 portable fire extinguishers What corrective action will be were inspected at least monthly and the accomplished for those inspections were documented including the date residents found to have been and initials of the person performing the affected by the alleged inspection in accordance with NFPA 10. LSC deficient practice? 9.7.4.1 states portable fire extinguishers shall be Portable fire extinguishers were selected, installed, inspected and maintained in inspected and documented. accordance with NFPA 10. NFPA 10, the How other residents having the Standard for Portable Fire Extinguishers, 2010 potential to be affected by the Edition, Section 7.2.1.2 states fire extinguishers same deficient practice will be shall be inspected either manually or by means of identified and what corrective an electronic monitoring device/system at a action will be taken: minimum of 30-day intervals. Where monthly Current maintenance director was manual inspections are conducted, the date the provided reeducation regarding fire manual inspection was performed and the initials equipment maintenance and of the person performing the inspection shall be inspection. recorded. Where manual inspections are What measures will be put into conducted, records for manual inspections shall place or what systemic be kept on a tag or label attached to the fire changes will be made to

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extinguisher, on an inspection checklist

the last 12 monthly inspections have been

maintained on file, or by an electronic method.

Records shall be kept to demonstrate that at least

performed. This deficient practice could affect 30

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ensure that the deficient

practice does not recur:

6 months that portable fire

The Administrator /designee will

be responsible to review monthly x

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155606		B. WING 02/10/2025			
		100000	3			02/10/	2020
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
WESTSI	DE RETIREMENT \	/ILLAGE			APOLIS, IN 46234		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	compartments.	visitors in two smoke			extinguisher inspections has be completed, and the document		
	compartments.				has been uploaded into the TE		
	Findings include:				system.		
					How the corrective action wi	II	
	Based on observation	ons with the Maintenance			be monitored to ensure the		
		tive Director during a tour of			deficient practice will not		
		20 p.m. to 4:00 p.m. on 02/10/25,			recur:		
	_	mounted ABC type portable fire			The results of these reviews w		
	_	had missing monthly ntation on contractor affixed			discussed at the monthly facili Quality Assurance Committee	•	
	-	rithin the most recent twelve			meeting monthly for three mon		
	month period:	timi the most recent twerve			and then quarterly for a total of		
	•	oreakroom since October 2024.			months. Re-education, freque		
	b. in the Central Su	pply room in the service hall			and/or duration of reviews will	•	
	since May 2024.				increased as needed if any ar	eas	
	-	tinguisher inspection			of noncompliance are identifie		
		ted a hanging tag to each fire			during the auditing process ur		
		annual maintenance was			compliance has been reached	i . .	
	-	2024. Based on interview at the tions, the Maintenance			Date of Compliance: 3/3/25		
	Director stated addi						
		tion documentation was not					
	available for review						
	aforementioned por	table fire extinguisher					
		missing monthly inspection					
		nin the most recent twelve					
	month period.						
	These findings war	e reviewed with the Executive					
	_	enance Director during the exit					
	conference.	change Director during the exit					
	3.1-19(b)						
K 0712	NFPA 101						
SS=F Bldg. 03	Fire Drills						
g. 00		view and interview, the facility narterly fire drills for 1 of 4	K 07	712	K712 What corrective action will b	e	03/03/2025

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPL	ETED
		155606	B. W	ING		02/10/	2025
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			/ 10TH ST		
WESTSI	DE RETIREMENT \	/ILLAGE			IAPOLIS, IN 46234		
WESISII	OF VEHIVEIMENT /	ALLAGE		INDIAN			
(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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	quarters. LSC 19.7.	1.6 requires drills to be			accomplished for those		
	conducted quarterly on each shift under varied				residents found to have been	n	
	conditions. This def	ficient practice affects all staff			affected by the alleged		
	and residents.				deficient practice?		
					Fire drills are current and have	е	
	Findings include:				been reviewed and document	ed.	
					How other residents having	the	
	Based on record rev	view of the "Fire Drills " forms			potential to be affected by th	ie	
	with the Maintenan	ce Director and the Executive			same deficient practice will b	ре	
		5 from 10:40 a.m. to 2:20 p.m.,			identified and what correctiv	re	
	there was no docum	nentation for a second shift fire			action will be taken:		
	drill in the third qua	arter (July, August, September)			Current maintenance director	was	
	of 2024. Based on i	nterview at the time of record			provided education regarding	the	
	review, the Mainter	nance Director stated he has			monthly scheduled completion	n of	
	been on the job a fe	w months and confirmed there			fire drills.		
	are no additional fir	re drills for review at the time of			What measures will be put ir	nto	
	the survey.				place or what systemic		
					changes will be made to		
	This finding was re	viewed with the Executive			ensure that the deficient		
	Director and Mainto	enance Director at the exit			practice does not recur:		
	conference.				The Administrator /designee v	vill	
					be responsible to review mont	thly x	
	3.1-19(b)				6 months fire drills have been		
	3.1-51(c)				completed, and the document	ation	
					has been uploaded into the Ti	ELS	
					system.		
					How the corrective action wi	II	
					be monitored to ensure the		
					deficient practice will not		
					recur:		
					The results of these reviews w	vill be	
					discussed at the monthly facili	ity	
					Quality Assurance Committee	;	
					meeting monthly for three mor	nths	
					and then quarterly for a total o	of 6	
					months. Re-education, freque	ncy	
					and/or duration of reviews will	be	
					increased as needed if any are	eas	
					of noncompliance are identifie		
					during the auditing process ur		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155606		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 02/10/2025	
	PROVIDER OR SUPPLIEF		8616	ET ADDRESS, CITY, STATE, ZIP COD S W 10TH ST ANAPOLIS, IN 46234	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) O BE PRIATE COMPLETION DATE
				compliance has been reac Date of Compliance: 3/3/3	
K 0918 SS=F Bldg. 03	NFPA 101 Electrical Systems	s - Essential Electric Syste			
	facility failed to may of monthly generated last 12 months. Ch NFPA 99 requires a generator serving the to be in accordance for Emergency and Chapter 8. NFPA 1 generator sets in seconce monthly, for a Chapter 6.4.4.2 of 1 record of inspection period, and repairs regularly maintained by the authority has deficient practice of Findings include: Based on record repulation of the job a few month documentation of a generator for June to not available for residuals.		K 0918	What corrective action will accomplished for those residents found to have be affected by the alleged deficient practice? The monthly generator load and weekly generator inspirate been completed. How other residents having potential to be affected by same deficient practice will dentified and what correct action will be taken: Current maintenance direct provided education on the requirements for maintaining facility generator load testified documentation. What measures will be puplace or what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator /designed be responsible to review most form of months that the monthly generator load test with documentation is completed logged into the TELS systems.	d test, ection ng the y the rill be ctive tor was ng and at into ee will conthly x and and com. a will
		viewed with the Executive enance Director at the exit		be monitored to ensure the deficient practice will not recur:	

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Event ID:

 $ZFVR21 \qquad {\tt Facility\ ID:} \quad 000497$

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	03	COMPL	
		155606	B. WI	NG		02/10	/2025
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					10TH ST		
WESTSI	DE RETIREMENT \	/ILLAGE		INDIAN	APOLIS, IN 46234		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG		ill bo	DATE
	2 Rased on record	review and interview the			The results of these reviews w discussed at the monthly facili		
	2. Based on record review and interview, the facility failed to ensure a written record of weekly				Quality Assurance Committee	-	
		emergency generator was			meeting monthly for three mor		
	-	52 weeks. NFPA 99, 6.4.4.1.3			and then quarterly for a total o		
		erators shall be maintained in			months. Re-education, freque		
	accordance with NI	FPA 110, Standard for			and/or duration of reviews will	-	
		ndby Power Systems. NFPA			increased as needed if any are		
		an Emergency Power Supply			of noncompliance are identifie		
		luding all appurtenant			during the auditing process un		
		be inspected weekly and			compliance has been reached	l.	
	-	NFPA 99, 6.4.4.2 requires a spection, performance,			Date of Compliance: 3/3/25		
		and repairs for the generator to					
	• •	ined and available for					
		ithority having jurisdiction.					
		ice could affect all residents,					
	staff and visitors.						
	Findings include:						
	Dogad on monand nor	viany of Emangeman Computan					
		view of Emergency Generator on with the Maintenance					
	_	a.m. to 2:20 p.m. on 02/10/25,					
		aspection documentation for					
		veeks was not available for					
		of 04/13/24, 07/27/24, all of					
		eeks in September 2024 were					
	not not available. B	ased on interview at the time					
		e Maintenance Director stated					
		the job a few months and had					
		r weekly generator inspection					
		there are no additional weekly					
	generator inspection	ns at the time of the survey.					
	This finding was re	viewed with the Executive					
	Director and Maintenance Director during the exit						
	conference.	·8					
	3.1-19(b)		1				1

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Event ID:

 $ZFVR21 \qquad {\tt Facility\ ID:} \quad 000497$

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 03			COMPLETED		
		155606	B. WING		02/10/2025			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD					
NAME OF PROVIDER OR SUPPLIER			8616 W 10TH ST					
WESTSI	DE RETIREMENT V	/ILLAGE	INDIANAPOLIS, IN 46234					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE	

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