STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING -- B. WING	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTSIDE RETIREMENT VILLAGE	8616 W 10TH ST INDIANAPOLIS, IN 46234

(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: 02/10/25 Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530 At this Emergency Preparedness survey, Westside Retirement Village was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 132 certified beds. At the time of the survey, the census was 88. Quality Review completed on 02/12/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to document exercises which tested the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not	E 0039	K039 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The after-action reports have been completed for 12/24/24 and 10/31/24 of the table top	03/03/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maurice Woolfolk	Executive Director	02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Management Plan" documentation with the Executive Director and Maintenance Director during record review from 10:40 a.m. to 2:20 p.m. on 02/10/25, documentation for a facility based drill and tabletop exercise that challenged the emergency plan within the most recent year period was incomplete. Documentation for a tabletop exercise conducted on 12/27/24 and a facility based exercise conducted on 10/31/24 did not include an		exercises. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided education regarding the completion of after-action report completion. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator /designee will be responsible to review monthly x 6 months that after action report has been completed and the documentation is in the emergency management plan binder. **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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	155606	A. BUILDING -- B. WING	02/10/2025

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	after action report. Based on interview at the time of record review, the Maintenance Director agreed that after action report documentation for the two exercises were not available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference.			
K 0000 Bldg. 03	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: 02/10/25 Facility Number: 000497 Provider Number: 155606 AIM Number: 100291530 At this Life Safety Code survey, Westside Retirement Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 132 and had a	K 0000		

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	census of 88 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered. Quality Review completed on 02/12/25			
K 0291 SS=C Bldg. 03	NFPA 101 Emergency Lighting Based on record review, observation, and interview; the facility failed to ensure documentation was provided for the testing of battery powered emergency light units that were tested monthly for 30 seconds during 1 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 02/10/25 at 1:33 p.m. with the Maintenance Director present, the facility's preventative maintenance report indicated the battery powered emergency light	K 0291	K291 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The battery powered 30 second emergency light tests have been completed and documented. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided education regarding the completion of emergency light tests. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator /designee will be responsible to review monthly x 6 months that battery powered emergency light tests are completed and the documentation is in the TELS system.	03/03/2025

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	units were tested monthly for 30 seconds, however, there were no 30 second tests performed in August of 2024. Based on an interview at the time of record review, the Maintenance Director stated there were no monthly 30 second tests performed during August 2024 due to Maintenance staffing issues. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**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**	
K 0300 SS=C Bldg. 03	NFPA 101 Protection - Other Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include:	K 0300	K300 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Battery-operated smoke detectors in resident rooms were inspected and documented. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided education regarding the inspection and documentation of battery-operated smoke detectors in resident rooms. **What measures will be put into**	03/03/2025

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	Based on records review and observation with the Maintenance Director and Executive Director on 02/10/25 between 10:40 a.m. and 2:20 p.m., preventative maintenance documentation of resident room battery operated smoke alarms was not available for the weeks of 8/3/24, 8/10/24, 8/17/24 and 9/28/24. Based on interview at the time of review, the Maintenance Director stated no other documentation for battery operated smoke detector testing was available at the time of the survey. During the tour of the facility, battery operated smoke detectors were observed in the resident sleeping rooms. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator /designee will be responsible to review monthly x 6 months that battery-operated smoke detectors in resident rooms have been inspected, documented and put in the TELS system. **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**	
K 0351 SS=E Bldg. 03	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in the facility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff, visitors and	K 0351	K0351 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Resident room 111 bathroom and dry goods storage room in the kitchen were identified as having	03/03/2025

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	up to 30 residents in two smoke compartments. Findings include: Based on observation with the Executive Director and Maintenance Maintenance Director on 02/10/25 during a tour of the facility at 2:55 p.m., the bathroom in resident room 111 had a missing sprinkler escutcheon. Additionally, the sprinkler located in a dry goods storage room in the kitchen was missing an escutcheon. Based on interview at the time of each observation, the Maintenance Director confirmed the escutcheons were missing. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		missing sprinkler escutcheons. Fire sprinkler contractor was notified, and escutcheons have been ordered for installation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided education regarding the inspection of fire sprinkler escutcheons. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** 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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K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of sprinkler gauge and control valve documentation for the most recent twelve month period with the Maintenance Director during record review from 10:40 a.m. to 2:20 p.m. on 02/10/25, monthly wet sprinkler system gauge and control valve inspection documentation for three of the most recent 12 month period was also not available for review. The months of July, August and September 2024 were not available. Based on interview at the time of record review, the Maintenance Director confirmed that sprinkler system gauge and control valve inspection documentation for the aforementioned monthly	K 0353	K0353 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Sprinkler system gauge and control valve checks have been completed and documented. The sprinkler heads in the laundry room have been cleared of lint. Sprinkler heads have been inspected to ensure no lint or debris is present. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided education regarding fire equipment maintenance and inspection of the sprinkler gauges and valves. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator /designee will be responsible to review monthly x 6 months that the sprinkler system gauge and control valve check has been completed, and the documentation has been uploaded into the TELS system. Also, fire sprinkler heads will be	03/03/2025

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	periods was not available for review. This finding was reviewed with the Executive Director and Maintenane Director at the exit conference. 2. Based on observation and interview; the facility failed to ensure three sprinkler heads in the washing machine area of the Laundry room covered with lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect two staff in the Laundry room. Findings include: 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		inspected x 6 months to ensure sprinklers are free of lint or debris. **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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	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 SS=E Bldg. 03	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 2 of 35 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 30	K 0355	K0355 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** Portable fire extinguishers were inspected and documented. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided reeducation regarding fire equipment maintenance and inspection. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator /designee will be responsible to review monthly x 6 months that portable fire	03/03/2025

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	residents, staff and visitors in two smoke compartments. Findings include: Based on observations with the Maintenance Director and Executive Director during a tour of the facility from 2:20 p.m. to 4:00 p.m. on 02/10/25, the following wall mounted ABC type portable fire extinguishers each had missing monthly inspection documentation on contractor affixed maintenance tags within the most recent twelve month period: a. in the employee breakroom since October 2024. b. in the Central Supply room in the service hall since May 2024. The portable fire extinguisher inspection contractor had affixed a hanging tag to each fire extinguisher stating annual maintenance was performed in May 2024. Based on interview at the time of the observations, the Maintenance Director stated additional monthly fire extinguisher inspection documentation was not available for review and agreed the aforementioned portable fire extinguisher locations each had missing monthly inspection documentation within the most recent twelve month period. These findings were reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		extinguisher inspections has been completed, and the documentation has been uploaded into the TELS system. **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**	
K 0712 SS=F Bldg. 03	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4	K 0712	K712 **What corrective action will be**	03/03/2025

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	quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drills " forms with the Maintenance Director and the Executive Director on 02/10/25 from 10:40 a.m. to 2:20 p.m., there was no documentation for a second shift fire drill in the third quarter (July, August, September) of 2024. Based on interview at the time of record review, the Maintenance Director stated he has been on the job a few months and confirmed there are no additional fire drills for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		**accomplished for those residents found to have been affected by the alleged deficient practice?** Fire drills are current and have been reviewed and documented. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided education regarding the monthly scheduled completion of fire drills. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator /designee will be responsible to review monthly x 6 months fire drills have been completed, and the documentation has been uploaded into the TELS system. **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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155606	A. BUILDING 03 B. WING	02/10/2025

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			compliance has been reached. **Date of Compliance: 3/3/25**	
K 0918 SS=F Bldg. 03	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for four of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 02/10/25 from 10:40 a.m. to 2:20 p.m., monthly under load documentation for June to September 2024 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he had been on the job a few months and confirmed that documentation of monthly load tests of the generator for June through September 2024 were not available for review. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.	K 0918	K0918 **What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?** The monthly generator load test, and weekly generator inspection has been completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Current maintenance director was provided education on the requirements for maintaining facility generator load testing and documentation. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Administrator /designee will be responsible to review monthly x 6 months that the monthly generator load test with documentation is completed and logged into the TELS system. **How the corrective action will be monitored to ensure the deficient practice will not recur:**	03/03/2025

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	2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator was maintained for 9 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review of Emergency Generator testing documentation with the Maintenance Director from 10:40 a.m. to 2:20 p.m. on 02/10/25, weekly generator inspection documentation for nine of the last 52 weeks was not available for review. The weeks of 04/13/24, 07/27/24, all of August and three weeks in September 2024 were not not available. Based on interview at the time of record review, the Maintenance Director stated that he had been on the job a few months and had searched records for weekly generator inspection documentation and there are no additional weekly generator inspections at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		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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