STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 10/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/16/14 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Norwood Health and Rehabilitation Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of halls 100, 200, 300 and the main dining room was surveyed with Chapter 19 Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in	K010000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	corridors and areas open to the corridor. Battery operated smoke detectors were installed in the resident rooms. The facility has a capacity of 88 and had a census of 52 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered include a detached garage used for storage of maintenance equipment and parts, and a detached sheds used for storage of lumber and another detached shed used for storage of kitchen equipment. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/20/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided			

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	with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 51 resident room corridor doors. This deficient practice could affect 1 of 6 smoke compartments. Findings include: Based on observation and interview with the Executive Director on 10/16/14 at 11:45 p.m., the corridor door to resident room 106 was obstructed by a resident bed and a privacy curtain. The Executive Director acknowledged and moved the bed and privacy curtain at the time of observation. 3.1-19(b)	K010018	K018 1. Door to room 106# was unobstructed by Executive Director on 10/16/14. 2. Maintenance Director inspected each door for further obstructions and corrected at that time. 3. Maintenance Director to inspect all doors 3 times weekly for 1 month, then weekly thereafter for compliance. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	11/13/2014
K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully			

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	ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 2 of 6 smoke compartments. Findings include: Based on observations with the Maintenance Director on 10/16/14 from 11:40 a.m. to 1:38 p.m., the following was noted: a. there were unsealed ceiling penetrations in the maintenance office/electrical room measuring from one inch to one fourth inch b there were unsealed ceiling penetrations in the room behind the dryers measuring one fourth and the collar around the exhaust vent of the two dryer had dropped out of place leaving a one fourth inch ceiling penetration c. the attic access panel were missing from the access near the 200 hall fire barrier wall and near the 300 hall fire barrier wall. Based on interview, the measurements were provided by the Maintenance	K010025	K025 1. Penetrations in Maintenance Office and room behind dryers sealed with fire caulk, collar around exhaust vent repaired, and access panels by 200 and 300# hall barriers put back in place. 2. Maintenance Director to inspect building for any further penetrations and that access panels are in place. 3. Maintenance Director/designee to inspect building weekly by walk through for penetrations, collars in correct placement around vents, and access panels in place. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	11/13/2014

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	Director and acknowledged at the time of observation. 3.1-19(b)			
K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure doors protecting hazardous areas were smoke resistive in 1 of 1 kitchens and 1 of 1 laundry rooms. This deficient practice could affect 1 of 5 smoke compartments. Findings include: Based on observation with the Maintenance Director on 10/16/14 at 12:39 p.m., the door entering the kitchen from the service hall was propped open. Based on an interview with the Maintenance Director at the time of observation, the corridor door was stuck	K010029	K029 1. Kitchen and Soiled Room doors adjusted for proper closure. 2. All service doors were inspected for proper closure, and if needed, repaired at that time. 3. Maintenance Director/designee to inspect all service doors weekly for proper closure and needed repairs. 4. Inspections will be forwarded to monthly Quality Assurance	11/13/2014

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	on an uneven area of the floor which prevented the door from self closing. At 1:40 p.m., the door entering the soiled linen side of the laundry room failed to close and latch into the door frame. Based on an interview with the Maintenance Director at the time of observation, the door was rubbing on the door frame. 3.1-19(b)		committee for tracking and trending. 5. Date to be completed: 11/13/14	
K010038 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 6 exit discharge paths was readily accessible at all times. LSC Section 7.1 requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2 Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect resident evacuated through the 300 hall exit in the event of an emergency. Findings include:	K010038	K038 1. Bus moved to proper location and hand rail outside 300# hall repaired. 2. All hand rails inspected to ensure in proper working order. Building transportation drivers re-educated on location to park bus. 3. Maintenance Director/designee to conduct weekly inspections to ensure hand rails in working condition, and bus parked in correct location. 4. Inspections will be forwarded to monthly Quality Assurance	11/13/2014

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	Based on observation with the Maintenance Director on 10/16/14 at 12:15 p.m., near the bottom of the 300 hall exit discharge sidewalk/ramp the handrail was leaning to one side instead of upright and secure. Additionally, the facility bus was parked at the bottom of the ramp blocking the path of egress to the public way. Based on an interview with the Maintenance Director at the time of observation, the supports at the sidewalk of the handrail were broken making the handrail lean to one side. 3.1-19(b)		committee for tracking and trending. 5. Date to be completed: 11/13/14	
K010048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to ensure the written fire plan included the different types and the use of fire extinguishers provided in the facility and staff response to the activation of a resident room battery operated smoke detector in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms	K010048	K048 1. Disaster Plan updated to reflect types of fire extinguishers throughout facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system and staff response to the activation of a resident room battery operated some detector. 2. Maintenance Director to re-educate staff on Disaster Plan, fire extinguishers and their classes, kitchen hood extinguishing system,	11/13/2014

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	(4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on a record review with the Maintenance Director on 10/16/14 at 11:05 a.m., the "Disaster Preparedness Plan" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen hood extinguishing system and staff response to the activation of a resident room battery operated smoke detector. This was confirmed by the Maintenance Director at the time of record review. 3.1-19(b)		and staff response to resident room battery operated alarms. 3. Maintenance Director/designee to audit Disaster Plan monthly to ensure updated as needed. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	
K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the	K010062	K062	11/13/2014

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	facility failed to ensure the spray pattern for the sprinkler heads in 1 of 1 record storage rooms on the 300 hall and 1 of 2 assisted dining room closets were unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 6 residents in the assisted dining room and any resident near the 300 hall record storage room in the event of an emergency. Findings include: Based on observations with the Maintenance Director on 10/16/14 at 12:05 p.m., the spray pattern of the sprinkler head in the 300 hall record storage room was obstructed by cardboard boxes of records stored on the top shelf to within five inches of the ceiling. Measurements were provided by the Maintenance Director at the time of observation. At 12:30 p.m., the sprinkler head in the closet near the back wall of the assisted dining room was obstructed by fabric and yawn stacked on the top shelf. This was acknowledged by the		1. Boxes in 300# record room and items in closet in assisted dining room removed. 2. Building inspected for any items that may obstruct spray patterns of sprinkler systems, and if found, removed. 3. Maintenance Director/designee to inspect building weekly to ensure sprinkler system spray patterns not obstructed. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	

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	Maintenance Director at the time of observation. 3.1-19(b)			
K010066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 resident smoking areas and 1 of 1 staff smoking areas were properly maintained and provided with a self closing trash receptacle used to empty ashtrays only. This deficient practice could affect residents in the smoking area and facility staff.	K010066	K066 1. Resident smoking area trash can replaced with a metal container with self closing, covered, receptacle. Cigarettes picked up in staff smoking area. 2. The facility will maintain the resident cigarette receptacle and designated staff smoking area for cleanliness and proper disposal. 3. Maintenance Director/designee to inspect	11/13/2014

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	Findings include: a. Based on observation and interview, the Maintenance Director on 10/16/14 at 12:00 p.m.,acknowledged the resident smoking area did not have a metal container with a self closing covered receptacle provided to empty ashtrays. b. Based on observation and interview, the Maintenance Director on 10/16/14 at 1:45 p.m., acknowledged there were at least 50 cigarette butts in the gravel of the staff smoking area. 3.1-19(b)		resident and staff designated smoking areas, and cigarette receptacles, 3 times weekly for 1 month, then weekly thereafter to ensure compliance. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	
K010073 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 Based on observation and interview, the facility failed to ensure 1 of 52 resident room corridor doors was free of combustible decorations. This deficient practice could affect any of the 30 residents on the 300 hall. Finding include: Based on observation and interview with the Maintenance Director on 10/16/14 at 12:10 p.m., he acknowledged the corridor	K010073	K073 1. Crepe paper on 311# door removed. 2. Resident room corridor doors inspected to ensure all free of combustible decorations, and if found, removed at that time. 3. Maintenance Director/designee to inspect resident doors 3 times weekly for 1 month, then weekly	11/13/2014

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	door to resident room 311 was completely covered with a decoration made out of crepe paper. 3.1-19(b)		thereafter. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	
K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose.	K010130	K 130 1. Attic fire barrier wall penetrations were sealed with fire caulk. 2. Maintenance Director to inspect building for any further penetrations, and repair, at that time. 3. Maintenance Director/designee to inspect building weekly for any further penetrations. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	11/13/2014

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	(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect residents in 2 of 6 smoke compartments. Findings include: Based on an observation with the Maintenance Director on 10/16/14 at 1:30 p.m., the attic fire barrier wall near the therapy room had two unsealed penetration measuring in size from two inches to one inch around conduit. Based on interview, the measurements were provided by the Maintenance Director and acknowledged at the time of observation. 3.1-19(b)			
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National			

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	Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on observation with the Executive Director and the Maintenance Director on 10/16/14, both acknowledged a heavy weight extension cord was plugged in and providing power to a power strip which was providing power to computer equipment in the Maintenance office/electrical room. 3.1-19(b)	K010147	K 147 1. Extension cord was removed from maintenance office. 2. Building inspected for any extension cords used as a substitute for fixed wiring, and replaced, if needed. 3. Maintenance Director/designee to inspect building weekly for extension cords used as a substitute for fixed wiring. 4. Inspections will be forwarded to monthly Quality Assurance committee for tracking and trending. 5. Date to be completed: 11/13/14	11/13/2014
K020000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).	K020000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155444	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 10/16/2014
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	Survey Date: 10/16/14 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Norwood Health and Rehabilitation Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association(NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The new section of the building consisting of the Therapy room and the electrical room where the generator switch is located was surveyed with Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridor. Battery operated smoke detectors went installed in the resident rooms. The facility has a capacity of 88 and had a census of 52 at the time of this survey.		provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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	All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts, and a detached sheds used for storage of lumber and another detached shed used for storage of kitchen equipment. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/20/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			