

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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	<p>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).</p> <p>Survey Date: 03/04/14</p> <p>Facility Number: 000015 Provider Number: 155041 AIM Number: 100273750</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Northwest Manor Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (200) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to</p>	K010000		
---------	---	---------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
	<p>the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 126 and had a census of 113 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing laundry services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/11/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224		
(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	
K010018 SS=E	<p>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 1¼ 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 with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 60 corridor doors would close, latch and resist the passage of smoke. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Dish Room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, the corridor door to the Dish Room had two, one quarter inch in diameter holes above and below the door handle which were not smoke resistant. Based on interview at the time of</p>	K010018	<p>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 because it is required by the provisions of federal and state law.</p> <p>K018</p> <p>I) The door handle to the dish room door has been replaced.</p> <p>II) Doors handles have been checked throughout the building for holes above and below the door handle.</p> <p>III) Door handles have been added to the preventative maintenance program.</p>	03/19/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
K010025 SS=E	<p>observation, the Maintenance Director acknowledged the aforementioned corridor door would not resist the passage of smoke for at least 20 minutes.</p> <p>3.1-19(b)</p> <p>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 ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure openings through 1 of 7 smoke barrier walls were protected to maintain the one half hour fire resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a</p>	K010025	<p>IV) Maintenance will check the doorhandles monthly for 3 months then quarterly thereafter. Administrator to monitor. QAPI committee to review and give direction as appropriate.</p> <p>K025 I) The hole in the wall (#1) & ceiling (#2) have been repaired in wing 1 mechanical room. II) Walls & ceiling have been checked throughout the building for holes. III) Walls & ceiling will be added to the preventative maintenance program. IV) Maintenance will check the walls & ceiling quarterly for 3 quarters then annually thereafter. Administrator to monitor. QAPI committee to review and give</p>	03/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224		
(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	
	<p>material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Wing 1 Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, a one and a half foot long by eight inch wide hole in the drywall above an electrical panel in the Wing 1 Mechanical Room failed to maintain the one half hour fire resistance for the smoke barrier wall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the Wing 1 Mechanical Room smoke barrier wall did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice</p>		direction as appropriate.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
	<p>could affect 10 residents, staff and visitors in the vicinity of the Wing 1 Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, an eight inch long by four inch wide hole in the ceiling above an electrical panel in the Wing 1 Mechanical Room for the passage of five conduits exposed the attic above which did not provide at least a one half hour fire resistance rating for the ceiling smoke barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the Wing 1 Mechanical Room ceiling did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224		
(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	
K010029 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas such as fuel fired heater rooms were separated from other areas by smoke resistant partitions. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the Wing 1 Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, a one and a half foot long by eight inch wide hole in the wall and an eight inch long by four inch wide hole in the ceiling above an electrical panel in the Wing 1 Mechanical Room failed to separate this hazardous area from other spaces by smoke resistant</p>	K010029	<p>K029</p> <p>I) The hole in the wall & ceiling have been repaired in wing 1 mechanical room.</p> <p>II) Walls & ceiling have been checked throughout the building for holes.</p> <p>III) Walls & ceiling will be added to the preventative maintenance program.</p> <p>IV) Maintenance will check the walls & ceiling quarterly for 3 quarters then annually thereafter. Administrator to monitor. QAPI committee to review and give direction as appropriate.</p>	03/19/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
K010046 SS=C	<p>partitions. The Wing 1 Mechanical Room contained two natural gas fired water heaters. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings did not separate the Wing 1 Mechanical Room from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery powered lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. 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, staff and visitors in the facility.</p>	K010046	<p>K046</p> <p>I) The emergency lights testing documentation was available for review.</p> <p>II) The emergency lights testing documentation was available for review.</p> <p>III) A separate (red) Life Safety binder has been created to organize the emergency lights testing documentation.</p> <p>IV) The emergency lights testing does take place by Maintenance monthly for a minimum of 30 seconds. Results of the test are recorded in the new (red) Life</p>	03/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
	<p>Findings include:</p> <p>Based on review of "Direct Supply TELS" documentation with the Administrator during record review from 9:30 a.m. to 12:30 p.m. on 03/04/14, documentation of functional testing for the two battery operated emergency lights in the facility at 30 day intervals for not less than 30 seconds for the five month period of March 2013 through July 2013 was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, one battery operated emergency light was located in the facility at the automatic transfer switch location and one battery operated emergency light was located inside the oxygen storage and transfilling room. Each of the aforementioned lights operated when their respective test button was pushed. Based on interview at the time of record review and at the time of the observations, the Administrator and the Maintenance Director acknowledged documentation of monthly functional testing documentation for the two battery operated emergency lights in the facility at 30 day intervals for not less than 30 seconds for the five month period of</p>		<p>Safety binder. Administrator to monitor. QAPI committee to review and give directions appropriate.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
K010050 SS=C	<p>March 2013 through July 2013 was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Direct Supply TELS: Fire Drills" & "Fire Drill Report" documentation with the Administrator during record review from 9:30 a.m. to</p>	K010050	<p>K050</p> <p>I) The fire drills were conducted quarterly at unexpected times on the first shift and was available for review.</p> <p>II) The fire drills were conducted quarterly at unexpected times on the first shift and was available for review.</p> <p>III) A separate (red) Life Safety binder has been created to organize the fire drill documentation.</p>	03/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
	<p>12:30 p.m. on 03/04/14, first shift fire drills conducted on 04/25/13, 09/08/13, 10/18/13 and 11/27/13 were conducted at, respectively, 2:16 p.m., 1:36 p.m., 2:29 p.m. and 1:29 p.m. Based on interview at the time of record review, the Administrator acknowledged first shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>		<p>IV) The fire drills are held at unexpected times by Maintenance and/or designee at least quarterly on each shift. Results of the fire drills are recorded in the new (red) Life Safety binder. Administrator to monitor. QAPI committee to review and give directions as appropriate.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 9 manual fire alarm box initiating devices in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, Section 2-8.1 states each manual fire alarm box shall be securely mounted and the operable part of the fire alarm box shall be not less than 3 1/2 feet and not more than 4 1/2 feet above the floor. Each installed initiating device shall be accessible for periodic maintenance and testing. This deficient practice could affect 26 residents, staff and visitors in the vicinity of Room 149.</p>	K010051	<p>K051</p> <p>I) The operable part of the manual firealarm box located in the corridor outside Room 149 has been moved to stateregulation height.</p> <p>II) The operable part of the manual fire alarm boxes have been checkedthroughout the building to ensure state regulation height.</p> <p>III) SafeCare relocated two (2) additional operable parts of the manual firealarm boxes.</p> <p>IV) SafeCare will continue to provide preventative maintenance</p>	03/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224		
(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	
	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, the operable part of the manual fire alarm box located in the corridor outside Room 149 was mounted on the wall 61 inches above the floor. Based on interview at the time of observation, the Maintenance Director acknowledged the operable part of the aforementioned fire alarm box was mounted on the wall more than 4 1/2 feet above the floor.</p> <p>3.1-19(b)</p>		<p>to the firealarm system annually. Maintenanceand/or designee to monitor. QAPI committeeto review and give direction as appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.3.4 states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, two sprinklers in the oxygen storage and transfilling room were located 55 inches apart from one</p>	K010056	<p>K056</p> <p>I) The sprinklers in the oxygen &transfilling room have been spaced not less than 6 feet.</p> <p>II) The sprinklers have been checked throughout the building during the LifeSafety tour for spacing not less than 6 feet.</p> <p>III) The Life Safety surveyor and the Maintenance Director did not findadditional sprinklers that were spaced not less than 6 feet.</p> <p>IV) SafeCare will continue to provide preventative maintenance to the sprinkler system quarterly. Maintenance and/or designee tomonitor. QAPI committee to review andgive direction as appropriate.</p>	03/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
K010062 SS=E	<p>another and a third sprinkler was located 61 inches from the second sprinkler location. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler locations were spaced less than six feet apart from another sprinkler.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 26 residents, staff and visitors.</p> <p>Findings include: Based on observations with the</p>	K010062	<p>K062</p> <p>I(1)The escutcheon plates for the automatic sprinkler heads for the Medical Supply closet by Room 153, the bathroom to Room 159 and Room 160 were pushed back into place during the tour with the Life Safety surveyor.</p> <p>2)The automatic sprinkler head in wing 2 housekeeping closet was replaced.</p> <p>II) (1)The escutcheon plates for the automatic sprinkler heads were checked during the Life</p>	03/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224		
(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	
	<p>Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, the automatic sprinkler located on the ceiling of the Medical Supply closet by Room 153, the bathroom to Room 159 and Room 160 each had a missing escutcheon plate which left a two inch opening in the ceiling. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinklers each had missing escutcheon plates which left a two inch opening in the ceiling.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers in the facility which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall 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, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 26 residents, staff and visitors in the vicinity of the Wing 2</p>		<p>Safety tour throughout the building.</p> <p>2)The automatic sprinkler heads were checkedduring the Life Safety tour throughout the building.</p> <p>III) (1)The Life Safety surveyor and Maintenance Director did not find any additionalautomatic sprinklers head escutcheon plates needing replaced.</p> <p>2)SafeCare did find three (3) additionalautomatic sprinklers heads needing replaced. They were replaced by SafeCare.</p> <p>IV) Maintenance will check the automatic sprinkler heads(1)/escutcheonplates (2) quarterly for 3 quarters then annuallythereafter. SafeCare will continue toprovide preventative maintenance to the sprinkler system quarterly. Administrator to monitor. QAPI committee to review and give directionas appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
	Housekeeping closet. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, the automatic sprinkler located in the Wing 2 Housekeeping closet had turned green with corrosion. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned automatic sprinkler was corroded. 3.1-19(b)						
K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 20 portable fire extinguishers each month. NFPA	K010064	K064 I)The fire extinguisher located in theBeauty Shop has been	03/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
	<p>10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 26 residents, staff and visitors in the vicinity of the Beauty Shop.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, the annual maintenance tag attached to the portable fire extinguisher located in the Beauty Shop indicated monthly inspections had not been documented for September 2013 through February 2014. Based on interview at the time of observation, the Maintenance Director stated no other monthly Beauty Shop fire extinguisher</p>		<p>inspected by Allied and the annual maintenance tag is upto date.</p> <p>II) Fire extinguishers have been checked throughout the building and the annual maintenance tags are up to date.</p> <p>III) The fire extinguisher located in the Beauty Shop has been added to the monthly preventative maintenance fire extinguisher itemized list.</p> <p>IV) Maintenance will continue to check the fire extinguishers monthly. Allied will continue to check the fire extinguishers annually. Administrator to monitor. QAPI committee to review and give direction as appropriate.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
K010067 SS=C	<p>inspection documentation was available for review and acknowledged monthly inspections for the aforementioned portable fire extinguisher were not documented for the period of September 2013 through February 2014.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>1. Based on record review, observation and interview; the facility failed to ensure egress corridors were not used as a portion of a return air system serving 85 of 85 adjoining rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors.</p>	K010067	<p>K067</p> <p>I(1)The return air system installationfor resident rooms and support rooms will be completed by Accu Temp in March2014.</p> <p>2) Thereturn air system installation for resident rooms and support rooms will havethe fusible links removed every 4 years beginning in 2018.</p> <p>3) The fire damper locations will be itemized in March 2014.</p> <p>II) (1) The return air system installation for resident rooms and supportrooms will be completed by Accu Temp in March 2014.</p> <p>2) Thereturn air system</p>	03/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224		
(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	
	<p>Findings include:</p> <p>Based on record review with the Administrator from 9:30 a.m. to 12:30 p.m. on 03/04/14, it could not be assured air conditioning, heating, ventilating ductwork and related equipment repair work to complete return air system installation for resident rooms and support rooms had been completed. Review of HC Ram "Invoice" documentation dated 04/10/13 stated return air system installation was completed. Review of Comfort Systems USA proposal letter dated 01/29/14 stated the facility's return air system installation and configuration needed to be corrected to ensure egress corridors were not used as a portion of a return air system. Based on interview at the time of record review, the Administrator stated HC Ram did not configure return air system installation correctly and Comfort Systems USA started repair work 01/31/14 and was to complete return air system corrections by 03/21/14. Documentation for the extent of reconfiguration at the time of the survey was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, it could not be determined what areas of the building return air</p>		<p>installation for resident rooms and support rooms will havethe fusible links removed every 4 years beginning in 2018.</p> <p>3) The fire damper locations will be itemized in March 2014.</p> <p>III) (1/2/3) Accu Temp began corrective repairs 1/31/14.</p> <p>IV) (1/2/3) Accu Temp will continue to provide preventative maintenance tothe heating, ventilation and air conditioning ductwork and related equipmentquarterly. Maintenance and/or designeeto monitor. QAPI committee to review andgive direction as appropriate.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
	<p>system reconfiguration had been performed to ensure egress corridors were not used as a portion of a return air system.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Comfort Systems USA "Job Status" documentation dated 09/05/12 during record review with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
K010130 SS=C	<p>Administrator from 9:30 a.m. to 12:30 p.m. on 03/04/14, documentation of an itemized listing of each fire damper location and the results of the test was not available for review. Based on interview at the time of record review, the Administrator stated there are fire dampers located throughout the facility and acknowledged an itemized listing of fire damper locations and the results of testing was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 68 of 68 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K010130	<p>K130</p> <p>I(a)The battery operated smokedetectors for resident sleeping rooms have been cleaned.</p> <p>b) The battery operated smoke detectorsfor resident sleeping rooms have been itemized.</p> <p>II) (a) The battery operated smoke detectors for resident sleeping roomshave been cleaned.</p>	03/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
	<p>Based on review of "Direct Supply TELS: Test battery operated smoke detectors" & "Battery Operated Smoke Detector Maintenance Log" documentation with the Administrator during record review from 9:30 a.m. to 12:30 p.m. on 03/04/14, the following was noted:</p> <p>a. documentation for battery operated smoke detector cleaning within the most recent twelve month period was not available for review.</p> <p>b. an itemized listing of battery operated smoke detector testing for August 2013 through February 2014 was not available for review. The results of testing battery operated smoke detectors in resident sleeping rooms are documented as being per wing and on a weekly basis.</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 4:30 p.m. on 03/04/14, battery operated smoke detectors are installed in each of 68 resident sleeping rooms. Manufacturer's specifications affixed to each First Alert Model SA340 smoke detector stated to clean the detector by "gently vacuum or use compressed air once per month."</p> <p>Based on interview at the time of record review and of the observations, the Administrator and the Maintenance Director acknowledged cleaning</p>		<p>b) The battery operated smoke detectors for resident sleeping rooms have been itemized.</p> <p>III) (a/b) A separate (red) Life Safety binder has been created to organize the battery operated smoke detectors documentation. The resident sleeping rooms have been itemized.</p> <p>IV) (a/b) Maintenance will clean the battery operated smoke detectors for resident sleeping rooms monthly. Maintenance will document that each resident sleeping room battery operated smoke detector was cleaned on an itemized form. Administrator to monitor. QAPI committee to review and give direction as appropriate.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
K010144 SS=C	<p>documentation for the most recent twelve month period and an itemized listing of battery operated smoke detector testing for August 2013 through February 2014 was not available for review.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 6 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be</p>	K010144	<p>K144</p> <p>I) Maintenance & the Administrator weretrained by SafeCare on accurate generator load bank documentation.</p> <p>A 4-hr load bank test was performed bySafeCare. The generator ran at 30%.</p> <p>II) Maintenance & the Administrator were trained by SafeCare on accurategenerator load bank documentation.</p> <p>A 4-hr load bank test was performed bySafeCare. The generator ran at 30%.</p> <p>III) A separate (red) Life Safety binder has been created to</p>	03/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/04/2014	
NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(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			
	<p>exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Direct Supply TELS: Emergency Power Generators" documentation with the Administrator during record review from 9:30 a.m. to 12:30 p.m. on 03/04/14, documentation for monthly load tests conducted during the six month period of August 2013 and October 2013 through February 2014 stated a maximum rating of 9.6 kilowatts was achieved for the 42 kilowatt generator which is less than 30% of the EPS nameplate rating. The</p>		<p>organize the generatorload bank documentation.</p> <p>IV) The facility is <u>not</u> required to have a professional load banktest ran in the future. The generatorload test takes place by Maintenance monthly. Results of the test are recorded in the new (red) Life Safetybinder. Administrator to monitor. QAPI committee to review and give directionas appropriate.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155041	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6440 W 34TH ST INDIANAPOLIS, IN 46224
--	---

(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
	<p>aforementioned monthly load test documentation did not indicate if the emergency generator ran under operating temperature conditions or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on interview at the time of record review, the Administrator acknowledged documentation for the monthly load tests conducted in August 2013 and October 2013 through February 2014 did not state the emergency generator ran for a minimum of 30 minutes under operating temperature conditions, at not less than 30% of the EPS nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>3.1-19(b)</p>			