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 10/15/2015

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
K 0000 Bldg. 01	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: 10/15/15 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910 At this Life Safety Code survey, Norwood Health and Rehabilitation Center was not 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 corridors and areas open to the corridor. Battery operated smoke detectors went	K 0000		

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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	installed in the resident rooms. The facility has a capacity of 88 and had a census of 50 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered 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 completed on 10/19/15 - DA			
K 0025 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall	K 0025	Ceiling in admissions office was sealed 10-19-15 Ceiling in sprinkler riser room was sealed 10-19-15 Ceiling in janitor closet in the kitchen was sealed 10-19-15 All residents have the potential to be affected by the deficient practice Maintenance	10/19/2015

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	to an outside wall. This deficient practice could affect 26 residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 10/15/15 at 11:11 a.m., the following areas had unsealed penetrations 1. In the ceiling of admissions office there were two unsealed fourth of an inch penetrations around a wires. 2. In the ceiling of sprinkler riser room there were four unsealed fourth of an inch penetrations around a piping. 3. In the ceiling of janitor closet in the kitchen there was an unsealed fourth of an inch penetration around a pipe. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetration. 3.1-19(b)		supervisor will audit building for the areas of deficiency by 10-30-15 Any deficient barrier will be corrected immediately Maintenance supervisor will follow any contractors who do work in the building to ensure no barrier are left unsealed Building will be audited for barrier deficiencies 1 X monthly for 6 months with audits going to the QA committee for review at which time QA to decide if audits need to continue	
K 0029 SS=E Bldg. 01	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			

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	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 1 of 5 corridor doors to the soiled utility room, a hazardous area, was provided with self closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect 22 residents in the 100 hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 10/15/15 at 10:30 a.m., the soiled utility room door by nurses' station #2 did self close but failed to latch into the frame. The soiled utility room contained barrels of trash and hazardous waste. Based on interview, this was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)	K 0029	Latch on soiled utility room door by nurses station #2 has been adjusted to latch automatically on 10-21-15 All residents have the potential to be affected by the deficient practice All door closures will be audited weekly and results given to QA committee for six months at which time QA will decide if there is a need for QA to continue to review	10/21/2015
K 0062 SS=F Bldg. 01	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			

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	1. Based on observation and interview, the facility failed to ensure 1 of 1 private fire hydrant systems were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on records review with the Maintenance Director on 10/15/15 at 9:55 a.m., the documentation tilted "Fire Hydrant Inspection" by Ryan Fire Protection stated the last inspection, testing, and maintenance for the facility's fire hydrants was conducted on 6/23/2014. Based on interview at the time of records review, the Maintenance Director confirmed the testing for the private fire hydrants was past due. 3.1-19(b) 2. Based on observation and interview,	K 0062	Annual inspection will be completed by November 6, 2015 That is the soonest the company could do the inspection. All residents have the potential to be affected by the deficient practice Annual inspection of the fire hydrant system will be added to TELS system	11/06/2015

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

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	the facility failed to replace 4 of over 40 sprinklers in the 200 hall which had been painted. 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 5 residents in the 200 hall. Findings include: Based on observation during the tour of the facility with the Maintenance Director on 10/15/15 between 11:20 a.m. and 11:40 a.m., the following automatic sprinklers had paint or plaster on the fusible link and/or the deflector. a. One sprinkler head in the closet of room 201 b. One sprinkler head in the closet of room 210 c. One sprinkler head in the closet of room 212 d. One sprinkler head in the closet of room 214 Based on interview at the time of observation, the painted sprinkler heads were acknowledged by the Maintenance			

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	Director. 3.1-19(b)			
K 0074 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure 1 of 1 sets of curtains located in the conference room was flame retardant. This deficient practice could affect up to 15 residents near the conference room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/15/15 at 9:40 a.m., there was a set	K 0074	Curtains in the conference room covering the dry erase board have had flame retardant applied on 10-16-15 All residents have the potential to be affect by the deficient practice Al new window coverings will be checked in through maintenance supervisor. All staff will be re-educated regarding this practice on 10-27-15	10/16/2015

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	of curtains covering a dry erase board in the conference room. Upon inspection of the curtains, no flame retardant rating was found. Based on interview at the time of observation, the Maintenance Director indicated there was no documentation regarding flame retardants for the curtains. 3.1-19(b)			
K 0143 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect up to 20	K 0143	Gaps in the Oxygen room door will be eliminated by 10-30-15 All residents have the potential to be affected by this deficient practice Door will be checked weekly with routine weekly door checks and results shared with QA for 6 months at which time QA will determine if QA needs to	10/30/2015

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	outside the service hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 10/15/15 at 12:02 p.m., the door to the oxygen transferring room had a one fourth inch gap at the top of the door when closed. Also, the door did not close tightly leaving a one fourth inch gap between the frame and the closed door. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the door gaps. 3.1-19(b)		continue to monitor	
K 0000 Bldg. 02	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: 10/15/15 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910	K 0000		

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 10/15/2015
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	At this Life Safety Code survey, Norwood Health and Rehabilitation Center was not 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 (111) 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 50 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered 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			

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	equipment. Quality Review completed on 10/19/15 - DA			
K 0062 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 private fire hydrant systems were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on records review with the Maintenance Director on 10/15/15 at 10:55 a.m., the documentation tilted "Fire Hydrant Inspection" by Ryan Fire Protection stated the last inspection,	K 0062	Annual inspection will be completed by November 6, 2015 That is the soonest the company could do the inspection. All residents have the potential to be affected by the deficient practice Annual inspection of the fire hydrant system will be added to TELS system	11/06/2015

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	testing, and maintenance for the facility's fire hydrants was conducted on 6/23/2014. Based on interview at the time of records review, the Maintenance Director confirmed the testing for the private fire hydrants was past due. 3.1-19(b)			