STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155041	A. BUILDING -- B. WING	02/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/07/23 Facility Number: 000015 Provider Number: 155041 AIM Number: 100273750 At this Emergency Preparedness survey, Northwest Manor Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 126 certified beds. At the time of the survey, the census was 102. Quality Review completed on 02/09/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/07/23 Facility Number: 000015 Provider Number: 155041 AIM Number: 100273750 At this Life Safety Code survey, Northwest	K 0000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bryce Reagan		02/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Manor Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type 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 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 102 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing laundry services which was not sprinklered. Quality Review completed on 02/09/23			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 egress doors equipped for delayed egress was equipped as required by LSC 7.2. LSC 7.2.1.6.1.(3) (4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 20 residents and staff using the exit door by resident room 134. Findings include: Based on observations during tour of the facility with the Maintenance Supervisor and Executive Director on 02/07/23 at 1:43 p.m., the single door exit by resident room 134 was provided with delayed egress but lacked the proper signage indicating the door can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Supervisor confirmed the egress door was equipped with a delayed egress and lacked the proper signage. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)	K 0222	p paraid="1718333131" paraeid="{be6eba57-e77d-4bfd-96bb-a78029ad908b}{186}" >It is the intention of Northwest Healthcare Center to provide the proper signage for doors equipped with a delayed egress locking device. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice: p paraid="8720808" paraeid="{be6eba57-e77d-4bfd-96bb-a78029ad908b}{205}" >On 2/8/2023, proper signage was obtained and applied to the door identified without proper signage. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken:	02/24/2023

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			·All other doors with delayed egress locking systems have proper signage intact. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Proper signage will be checked monthly on rounds completed by the Maintenance Director or . ol class="NumberListStyle1 SCXW71678458 BCX8" role="list" start="4" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: The Maintenance Director will review the monthly check-off with the Administrator for 3 months. Checking for proper signage on doors with delayed egress locking devices will become part of the monthly preventative maintenance check off. By what date the systemic changes will be completed:	

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			2/24/2023	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview; the facility failed to ensure all battery-operated smoke alarms in resident rooms were maintained. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 29.10 states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. Section 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff, and visitors. Findings include:	K 0300	p="" paraid="1718333131" paraeid="{1d591888-950f-4763-a7cf-1efa81bc23ff}{190}">It is the intention of Northwest Healthcare Center to maintain all battery powered smoke detectors according to manufacturer guidelines. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice: p="" paraid="8720808" paraeid="{1d591888-950f-4763-a7cf-1efa81bc23ff}{217}">The battery powered smoke detectors were replaced with new 10-year smoke detectors. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken: All battery powered smoke detectors in the facility were replaced with 10-year	02/26/2023

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	Based on observations during a tour of the facility with Maintenance Supervisor and Executive Director on 02/07/23 from 1:12 p.m. to 2:20 p.m., the battery-operated smoke detector mounted on the ceiling in resident rooms #166 and #142 were inspected. The smoke detectors stated '10 year smoke alarms' on the front, were manufactured on September 1, 2010 and were more than 10 years old. Based on interview with the Maintenance Supervisor at the time of the above-mentioned observations, he confirmed that the battery operated smoke detectors were more than 10 years old. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(c)		smoke detectors. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Smoke detector expirations dates will be logged the monthly preventative maintenance checklist. All battery powered smoke detectors in the facility were replaced. Moving forward, any smoke detector replacement will have the new expiration date logged on the monthly checklist for future monitoring. ol="" role="list" start="4" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Current smoke detector monitoring will continue with each smoke detector being listed on the monthly checklist for function and expiration date. This process will be reported in QAPI committee reviews. By what date the systemic changes will be completed: 2/26/2023	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,			

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	toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression system was completely maintained. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition at 10.2.6 requires automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (4) NFPA 17A. NFPA 17A, Wet Chemical Extinguishing Systems Inspection, Maintenance, and Recharging, requires wet chemical containers shall be subject to a hydrostatic pressure test at intervals not exceeding 12 years. This deficient practice was not in a resident area but could affect kitchen staff. Findings include: Based on record review on 02/07/23 from 10:45 a.m. to 1:12 p.m. with the Executive Director and Maintenance Supervisor, the 04/06/22 fire suppression inspection report for the range hood	K 0324	p="" paraid="1718333131" paraeid="{095fc312-49b9-48fb-9afa-053574bcc11d}{186}">It is the intention of Northwest Healthcare Center to maintain fire suppression system 12yr hydro test according to guidelines. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice: p="" paraid="8720808" paraeid="{095fc312-49b9-48fb-9afa-053574bcc11d}{205}">The facility notified the vendor and approved the 12-year hydrotest to be scheduled and completed. The inspection was scheduled and completed on 2/23/2023. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be	02/26/2023

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	noted "System Past Due for 12YR Hydro Test". The 10/17/22 fire suppression inspection report for the range hood noted "System due for Hydro: Pull station needs to be updated at hydro dome lights need to shut off and stay off while the exhaust fan turns on and stay on during system trip." Based on interview at the time of record review, the Executive Director said there was no documentation to show that the 12 year maintenance has taken place for the Ansul fire suppression system. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		taken: The facility notified the vendor and approved the 12-year hydrotest to be scheduled and completed. The inspection was scheduled and completed on 2/23/2023. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: The fire suppression system inspection frequency for 2023 is listed in the Life Safety Monitoring binder for the Maintenance Director or to verify completion. Future inspections scheduled less frequently are listed by the date of last completion and due date for next inspection. ol="" role="list" start="4" How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Inspection completion reports will be presented for review in the QAPI meetings. By what date the systemic changes will be completed: 2/26/2023	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a			

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	secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to ensure 6 of 6 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 1:12 p.m. to 2:20 p.m. on 02/07/23, the facility has supervised dry sprinkler system and had a total of three air and water pressure gauges. The manufacture date of 2016 was listed on the face of the water sprinkler system gauge. The other two gauges had a date of 2019 and 2020. Based on interview at the time of the observations, the Maintenance Supervisor stated he did not believe sprinkler system gauges had been recalibrated within the most recent five year period and	K 0353	p paraid="1718333131" paraeid="{a84a37de-6f77-4d07-b663-4e8c38d09afe}{186}" >It is the intention of Northwest Healthcare Center to ensure air and water gauges for the sprinkler system are replaced or tested every 5 years. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice: p paraid="8720808" paraeid="{a84a37de-6f77-4d07-b663-4e8c38d09afe}{207}" >The water sprinkler gauges were replaced on 2/22/23. All three gauges at that site were changed to coordinate replacement or recalibration of gauges on same schedule. How other resident having the	02/24/2023

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	confirmed documentation of sprinkler system gauge replacement or recalibration was not available for review for the sprinkler system gauge that was more than five years old. This finding was reviewed with the Executive Director at the exit conference. 3.1-19(b)		potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken: ·The other gauges were and compliance verified, three gauges at the site were replaced to coordinate future replacement(s) or recalibration(s) of gauges on same schedule, What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director or designee will check gauge dates annually. Vendors completing sprinkler inspections will include concerns with upcoming expiration dates in their report. Gauge expiration dates will be included on the yearly preventative maintenance inspection list in the Life Safety Survey binder. ol class="NumberListStyle1 SCXW263104898 BCX8" role="list" start="4" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" How the corrective action(s) will be	

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			monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: Inspection completion reports will be presented for review in the QAPI meetings. By what date the systemic changes will be completed: 2/24/2023	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 set of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly functioning coordinator to ensure the door which must close first always closes first. This deficient practice	K 0374	It is the intention of Northwest Healthcare Center to ensure smoke barrier doors function properly.	02/24/2023

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	could affect more than 40 residents, as well as staff and visitors while in the main dining room. Findings include: Based on observation on 02/07/23 at 1:50 p.m. during a tour of the facility with the Maintenance Supervisor and Executive Director, the set of barrier doors at Wing 2 Nurse Station and main dining room closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the door frame, however, it did not function correctly when tested several times. Based on interview at the time of observation, the Maintenance Supervisor agreed the coordinator did not allow the set of smoke barrier doors to function as designed. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		ol class="NumberListStyle1 SCXW89399822 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice: The smoke barrier door coordinator was adjusted to ensure proper function and closure on 2/7/2023. The door functioned properly once adjusted and proper function was verified by the Administrator on 2/7/2023. How other resident having the potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken: ·The smoke barrier door coordinator was adjusted to ensure proper function and closure on 2/7/2023. The door functioned properly once adjusted and proper function verified by the Administrator on 2/7/2023. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:	

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	155041	A. BUILDING 01 B. WING	02/07/2023

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			p paraid="1649227508" paraeid="{78306ac8-0c97-4da6-846a-514bb4a1f4fe}{40}" >The Maintenance Director or will check interior smoke barrier door weekly for a month. A monthly preventative maintenance checklist will be completed for interior smoke barrier doors with closer devices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: ·Monthly checklists will be completed monthly on interior smoke barriers with door closers and presented monthly in QAPI. By what date the systemic changes will be completed: 2/24/2023	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected			

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	and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and patients. Findings include: Based on record review with the Executive Director and Maintenance Supervisor on 02/07/23 at 11:58 a.m., there was no documentation of a completed fire drill for the third shift drill for the fourth quarter in 2022. Based on interview at the time of record review, the Maintenance Supervisor agreed the third shift drill for the fourth quarter in 2022 was not conducted. This finding was reviewed with the Executivev Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	p paraid="1924157418" paraeid="{778a1aab-d274-4cd2-bab6-9d767af1e3e1}{221}" >It is the intension of Northwest Manor Health Care Center to complete fire drills on each shift quarterly. 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice: Residents were not affected by the fire alarm not completed on night shift. The new fire alarm schedule will maintain compliance with fire drills completed on each shift in each quarter. ol class="NumberListStyle1 SCXW206617473 BCX8" role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" How other resident having the	02/26/2023

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			potential to be affected by the same deficient practice will be identified and that corrective action(s) will be taken: Residents were not affected by the fire alarm not completed on night shift. The new fire alarm schedule will maintain compliance with fire drills completed on each shift in each quarter. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: ·Fire drills for 2023 have been scheduled on the preventative maintenance schedule. The schedule includes a fire drill on each of the three shifts during each quarter. The schedule will be adhered to each month to ensure the drills are compliant. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place: p paraid="610832431" paraeid="{907ad42e-e604-4ce2-a597-cc6d0e475c27}{46}" >Fire drills completed each month will be reviewed and presented in QAPI meetings.	

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			By what date the systemic changes will be completed: 2/26/2023	