STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 01/02/2018				
	PROVIDER OR SUPPLIEF OD HEALTH AND F	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD  3720 N NORWOOD RD  HUNTINGTON, IN 46750			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000	conducted by the of Health in accord 483.73.  Survey Date: 1/ Facility Number Provider Number AIM Number: 1/ At this Emergen Norwood Health was found in subtemergency Prep Medicare and M Providers and Su The facility has a census of 18 at the Quality Review DA  The requirement	: 000463 r: 155444	E 00	000	This Plan of Correction is Norwald Skilled Nursing & Rehabilitation's credible allegated of compliance. We respectfully request a desk review.  Preparation and /or execution this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because is required by the provisions of federal and state law.	of t ment he et	
E 0015 SS=C Bldg	Based on record	review and interview, the	E 00	)15	What corrective actions(s) w	ill_	01/20/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155444		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING COMPLETED B. WING 01/02/2018		ETED			
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		3720 N	ADDRESS, CITY, STATE, ZIP COD NORWOOD RD NGTON, IN 46750		
NORWO (X4) ID PREFIX TAG	summary (EACH DEFICIENT REGULATORY OF facility failed to preparedness poinclude at a min subsistence need whether they even include, but are (i) Food, water, pharmaceutical sources of energy Temperatures to safety and for the of provisions; (EFire detection, esystems; and (Decent disposal in accordant accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the facility plan provided disposal in accordant failed and the failed a	statement of deficiencie acy must be preceded by full rescribentifying information ensure emergency licies and procedures imum, (1) The provision of ds for staff and residents, acuate or shelter in place, not limited to the following: medical, and supplies. (ii) Alternate by to maintain - (A) protect resident health and he safe and sanitary storage B) Emergency lighting; (C) extinguishing, and alarm he swage and waste rdance with 42 CFR his deficient practice could ents.				the be to be ice.	(X5) COMPLETION DATE
					meeting. Ongoing education of be provided as per regulation Emergency Operation Plans.		

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CENTERS FOI	OMB NO. 0938-039					
STATEMEN	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155444	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/02/2018	
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP COD I NORWOOD RD NGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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 0026 SS=C Bldg	Based on record facility failed to preparedness poinclude the role waiver declared accordance with the provision of alternate care sit management off CFR 483.73(b)(could affect all could affect	review and interview, the ensure emergency licies and procedures of the LTC facility under a by the Secretary, in section 1135 of the Act, in care and treatment at an e identified by emergency icials in accordance with 42 8). This deficient practice occupants.	E 0026	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 QAA Committee will review policy and procedures annually and all appropriate members will document the review.  What corrective actions(s) will be accomplished for those residents found to have been potentially affected by the deficient practice?  See Attached Document, titled: Norwood - Section VI (a)-EmergencyResponse - 1135 Wavier Process, which is the facilities written policy and procedure to address the loss of sewage and waste disposal in a emergency.  How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?  All residents at Norwood Health and Rehab have the potential to affected by this deficient practice.	e t	}

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LTC facility under a waiver declared by the Secretary. Based on interview at the time of

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What measures will be put into

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	of Correction identification number 155444	A. BUILDING  B. WING	onstruction 	COMPLETED 01/02/2018
	ROVIDER OR SUPPLIER  OD HEALTH AND REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP COD NORWOOD RD NGTON, IN 46750	
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	records review, the Maintenance Director agreed the plan did not address the role of the LTC facility under a waiver declared by the Secretary.		place or what systemic changes will be made to ensure that the deficient practice does not recur?	
	and Beereury.		Due to the nature of this newe compliance area, the policy is attached with this Plan of Correction, will be retained wit the Emergency Operations Pland will be reviewed by the QA Committee during January 20 meeting. Ongoing education who be provided as per regulation is Emergency Operations Plans.	h an, AA 18 vill for
			How the corrective action(s) will be monitored to ensure t deficient practice will not recur, i.e., what quality assurance program will be point place?	<u>he</u>
			The QAA Committee will revie policy and procedures annuall and all appropriate members vidocument the review.	y
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 483.90(a).	K 0000	This Plan of Correction is Norwall Skilled Nursing & Rehabilitation's credible allegatof compliance. We respectfully request a desk review.	ition
	Survey Date: 1/02/18		Preparation and /or execution this plan of correction does no constitute admission or agreer	t

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155444	B. WI	NG		01/02/	2018
NAME OF I	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					NORWOOD RD		
NORWO	OD HEALTH AND	REHABILITATION CENTER		HUNTIN	NGTON, IN 46750		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		COMPLETION DATE	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	by the provider of the truth of t	·he	DATE
	Facility Number				facts alleged or conclusions se		
	Provider Number			forth in the statement of			
	AIM Number: 1	.00290910			deficiencies. The plan of		
					correction is prepared		
		ety Code survey, Norwood			and/or executed solely because		
		abilitation Center was not			is required by the provisions o federal and state law.	1	
	found in compli	ance with Requirements for					
	Participation in	Medicare/Medicaid, 42					
CFR Subpart 483.90(a), Life Safety from							
Fire, the 2012 edition of the National Fire							
	Protection Association (NFPA) 101, Life						
	Safety Code (LS	SC) and 410 IAC 16.2. The					
		rveyed with Chapter 19					
		Care Occupancies.					
		Cure Coupumores.					
	This one story f	acility was determined to be					
	1	) construction and was fully					
		e facility has a fire alarm					
	_	<u>-</u>					
	_	oke detection in corridors					
	_	to the corridor. Battery					
	_	detectors went installed in					
		ms. The facility has a					
		nd had a census of 18 at the					
	time of this surv	rey.					
	All areas where	the residents have					
	customary acces	ss were sprinklered. Areas					
	providing facilit	ty services were sprinkled. A					
	detached garage	e used for storage of					
		uipment and parts, a					
	_	used for storage of lumber					
		ached shed used for storage					
			1				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155444		X2) MULTIPLE CONSTRUCTION A. BUILDING D1 COMPLETED 01/02/2018			
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  3720 N NORWOOD RD  HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0211 SS=E Bldg. 01	Of kitchen equips  Quality Review DA  NFPA 101 Means of Egress Means of Egress Aisles, passagewadischarges, exit loin accordance with of egress is contin	ment were not sprinkled.  completed on 01/08/18 -  General General ays, corridors, exit cations, and accesses are Chapter 7, and the means uously maintained free of			
	through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observ facility failed to paths maintained full use in case of	s modified by 18/19.2.2  110.1 ation and interview, the ensure 3 of 8 exit discharge I free of all obstructions to of emergency. This deficient fect all residents.	K 0211	It is the practice of this center comply with K-211 NFPA 101 Safety Code.  What corrective actions(s) where the second is the second in the second is the second in the second is the second in the se	Life
	facility with the 01/2/18 between the exits dischard dining room, and obstructed with the covering the entition interview at the Maintenance Din the weekend and	Maintenance Director on 12:28 a.m. and 2:00 p.m., ge paths from the 100 hall, I lounge exits were two to three inches of snow are path. Based on an time of observations, the rector stated it snowed over an one was available to alks and agreed it has been		Snow, as identified by Survey and Maintenance Director on was removed from pathways each exit by Maintenance Director on 1/2/17.  Education provided verbally to Maintenance Director on 1/2/2 and written format on 1/18/18 related to snow removal with respect to Life Safety Requirements and the Job Description expectation.	tour, at ector

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155444		A. BUILDING B. WING	01	COMPLETED 01/02/2018			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD  3720 N NORWOOD RD  HUNTINGTON, IN 46750				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	at least two days 3.1-19(b)			How other residents having a potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?  All residents at Norwood Heal and Rehab have the potential affected by this deficient practive deficient practice or what systemic changes will be made to ensure that the deficient practice does not recur?  Education provided verbally to Maintenance Director on 1/2/1 and written format on 1/18/18, related to snow removal policy procedures.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be prin place?  Maintenance Director, or designee, will document the dof new snowfall and date snow removal from sidewalks (this process will include ice melt be applied as needed and address snow removal at ½ inch or more accumulation ASAP) on a week snow removal at ½ inch or more accumulation ASAP) on a week basis for 8 weeks, then every other week for 8 weeks, then monthly for 2 months.	the e be e th to be ice.  7, / and  the  ut  ate v eing ss ore in		

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER  155444	A. BUILDING B. WING	01	COMPLETED 01/02/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP COD NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	shall include not lead provisions:  (1) Smoking shall I ward, or compartmeliquids, combustible used or stored and location, and such signs that read NC posted with the interest smoking.  (2) In health care of smoking is prohibite prominently placed secondary signs we smoking shall not in (3) Smoking by paresponsible shall be (4) The requirement apply where the passupervision.  (5) Ashtrays of not	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable the gases, or oxygen is and in any other hazardous area shall be posted with o SMOKING or shall be ternational symbol for no occupancies where ted and signs are at all major entrances, with language that prohibits be required. tients classified as not		Audit findings will be presente the QAA Committee monthly. Ongoing monitoring will contin Monthly per Preventive Maintenance Programing-TELS-Fire System The QAA Committee will revie findings and determine the nefor further monitoring and/or education per the QAA procest Compliance will be determined based on results of audits.	n. ow ed

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155444	B. W	ING		01/02/	/2018
		L	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R			I NORWOOD RD		
NORWO	OD HEALTH AND	REHABILITATION CENTER		HUNTII	NGTON, IN 46750		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION TAG  where smoking is permitted.		BEFEIENCTY		DATE		
	_	ers with self-closing cover					
	devices into which ashtrays can be emptied						
		vailable to all areas where					
	smoking is permit						
	18.7.4, 19.7.4						
	Based on observ	vation and interview; the	K 0	741	It is the practice of this center	to	01/20/2018
	facility failed to	ensure 1 of 1 smoking areas			comply with K-741 NFPA 101		
	were maintained	d by disposing cigarette butts			Smoking Regulations		
	in the provided:	metal or noncombustible		What corrective actions(s		/ill	
	_	self-closing cover devices.					
		ractice was not in a resident			found to have been potentia	lly	
	•	uld affect staff outside the			affected by the deficient		
					practice?		
	service hall exit	•					
					Cigarette butts found were immediately picked up and		
	Findings include	e:			properly discarded.		
					property dissaraca.		
	Based on observ	vation during a tour of the			All staff education provided		
	facility with Ma	intenance Director on			1/18/18 as written format in		
	01/2/18 at 11:59	a.m., in and around the			communication area and will be		
	staff smoking ar	rea there were 7 cigarette			provided as verbal format with		
	_	und. Based on interview at			mandatory in-service, in Janua 2018.	ary	
	_	rvation, the Maintenance			2010.		
		ed the quantity of cigarette			How other residents having	the_	
		1 , 0			potential to be affected by the	<u>ie</u>	
	•	sed of the butts that were on			same deficient practice will I		
	the ground.				identified and what corrective	<u>'e</u>	
					action(s) will be taken?		
	3.1-19(b)				As this was not in a resident a	area	
					staff outside the service hall e		
					have the potential to be affect		
					by this deficient practice.		
					What measures will be put in	<u>1to</u>	
					place or what systemic		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155444	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 01/02/2018
	ROVIDER OR SUPPLIE	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP COD NORWOOD RD NGTON, IN 46750	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				changes will be made to ensure that the deficient practice does not recur?	
				All staff education provided 1/18/18 as written format in communication area and will be provided as verbal format with mandatory in-service, in Janua 2018.	next
				Facility to have designee to au the staff smoking area and rep issues to QAA, as described in the following response.	oort
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be p in place?	<u>he</u>
				Housekeeping Director, or Designee, will audit Staff Smo Area 5 days a week x 8 weeks then weekly x8 weeks, then monthly x2 to ensure staff are using the appropriate receptace as provided to discard cigarett butts.	s,
				Audit findings will be presente the QAA Committee monthly. Ongoing monitoring will contin Monthly per Preventive Maintenance Programing-TELS-Fire System The QAA Committee will revie findings and determine the ne	n. ew

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155444	B. WI	NG		01/02/2018	
C. O. D. D.		<u></u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		3720 N	NORWOOD RD		
NORWO	OD HEALTH AND F	REHABILITATION CENTER		HUNTIN	NGTON, IN 46750		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					for further monitoring and/or	c	
					education per the QAA process.  Compliance will be determined		
					based on results of audits.	•	
K 0920	NFPA 101						
SS=D		ent - Power Cords and					
Bldg. 01	Extens Electrical Equipme	ent - Power Cords and					
	Extension Cords	ent - i ower oords and					
		patient care vicinity are only					
	used for compone	nts of movable					
patient-care-related electrical equipment (PCREE) assembles that have been							
		lified personnel and meet 0.2.3.6. Power strips in					
		cinity may not be used for					
		personal electronics),					
		n care resident rooms that					
		E. Power strips for PCREE					
		UL 60601-1. Power strips					
		the patient care rooms					
		) meet UL 1363. In poms, power strips meet					
		s. All power strips are					
		precautions. Extension					
		d as a substitute for fixed					
	_	re. Extension cords used					
		moved immediately upon					
		purpose for which it was the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	,	(D) (NFPA 70), TIA 12-5					
		ation and interview, the	K 09	920	It is the practice of this center	to	01/20/2018
		ensure 1 of 1 power strips			comply with K 920- NFPA 101		
	that were used for	or patient-care-related			Electrical Equipment, Power C and Extension.	ord	
	electrical equipn	nent (PCREE) met UL			and Emonorn.		
	1363A or UL 60	601-1 and 1 of 1 extension			What corrective actions(s) wi	<u>IIL</u>	
	cords was not us	ed as fixed wiring for			be accomplished for those		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155444	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 01/02/2018
	PROVIDER OR SUPPLIEI	REHABILITATION CENTER	3720 N	ADDRESS, CITY, STATE, ZIP COD N NORWOOD RD INGTON, IN 46750	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION (X5) LD BE ROPRIATE COMPLETION DATE
	PCREE. This de up to 2 residents	efficient practice could affect in one room.		residents found to have potentially affected by the deficient practice?	
	facility with the 01/2/18 at 1:19 pequipment that we resident was plus power by a pow UL 1363A or Upiece of medical an extension contime of observat Director agreed into an extension	rations during a tour of the Maintenance Director on p.m., in room 110 medical was currently used for a gged into and supplied er strip that did not meet L 60601-1 and a second I equipment was plugged in rd. Based on interview at the ions, the Maintenance that PCREE was plugged in cord and into a power strip red at UL 1363A or UL		Maintenance Director aud 2 resident's room on 1/2/2 respect to all items requiremed to be plugged in to a the appropriate receptack use.  Facility preparing to move 2 resident's to another roomenhancing privacy and all improved access to power in relation to the individual of the resident.  How other residents have potential to be affected and what corresidentified and what corresidentified and what corresidentified and what corresidents at Norwood and Rehab have the potential to be affected by this deficient polarized by this deficient polarized by this deficient polarized by the polarized or what systemic changes will be made to ensure that the deficient practice does not recur?  Education provided verbated written format on 1/18 related to Electrical Equipuse and extension cords/strips with respect to Life	18, with ing the ensure e was in  2 1 of the om, thus lowing for it supply all needs  2 ing the will be ective  Health intial to be oractice.  2 ing the oractice.  3 ing the oractice.  3 ing the oractice.  5 ing the oractice.  6 ing the oractice.  7 ing the oractice.  7 ing the oractice.  7 ing the oractice.  8 ing the ora

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155444		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/02/2018	
NAME OF PROVIDER OR SUPPLIER  NORWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD  3720 N NORWOOD RD  HUNTINGTON, IN 46750		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Requirements and the Job Description expectation. Education Provided to Housekeeping Director on 1/1 on Life Safety Requirements of preparation for audits of exters cord and power strip use. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be prin place?  Housekeeping Director, or Designee, will audit all reside occupied rooms weekly x8, the every other week x8, then monitored to ensure that no extension cords or power strips are in use the QAA Committee monthly. Ongoing monitoring Monthly preventive Maintenance Programing-TELS. The QAA Committee will review findings determine the need for further monitoring and/or education puthe QAA process. Compliance be determined based on resultants.	to aid nsion  L the  put  nt nen onthly n se. ed to per es and r per e will

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