STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155444	A. BUILDING -- B. WING	01/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORWOOD HEALTH AND REHABILITATION CENTER	3720 N NORWOOD RD HUNTINGTON, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 1/02/18 Facility Number: 000463 Provider Number: 155444 AIM Number: 100290910 At this Emergency Preparedness survey, Norwood Health and Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 88 and had a census of 18 at the time of this survey. Quality Review completed on 01/08/18 - DA The requirement at 42 CFR, Subpart 482.15 is NOT MET as evidenced by:	E 0000	This Plan of Correction is Norwood Skilled Nursing & Rehabilitation's credible allegation of compliance. We respectfully request a desk review. Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
E 0015 SS=C Bldg. --	Based on record review and interview, the	E 0015	**What corrective actions(s) will**	01/20/2018

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

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	facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 01/02/18 at 10:40 a.m., the facility's Emergency Preparedness plan provided did not address the loss of sewage and waste disposal in an emergency. Based on interview at the time of records review, the Maintenance Director agreed the plan did not address not address the loss of sewage and waste disposal in an emergency		**be accomplished for those residents found to have been potentially affected by the deficient practice?** See Attached Document, titled: *Norwood - Section VI (a)-EmergencyResponse - Sewage System Failure,* which is the facilities written policy and procedure to address the loss of sewage and waste disposal in an 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 be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Due to the nature of this newer compliance area, the policy is attached with this Plan of Correction, will be retained with the Emergency Operations Plan, and will be reviewed by the QAA Committee during January 2018 meeting. Ongoing education will be provided as per regulation for Emergency Operation Plans.	

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			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.	
E 0026 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 01/02/18 at 10:50 a.m., the facility's Emergency Preparedness plan provided did not address the role of the LTC facility under a waiver declared by the Secretary. Based on interview at the time of	E 0026	**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 an 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 be affected by this deficient practice. **What measures will be put into**	01/20/2018

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	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?** Due to the nature of this newer compliance area, the policy is attached with this Plan of Correction, will be retained with the Emergency Operations Plan, and will be reviewed by the QAA Committee during January 2018 meeting. Ongoing education will be provided as per regulation for Emergency Operations Plans. **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.	
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). Survey Date: 1/02/18	K 0000	This Plan of Correction is Norwood Skilled Nursing & Rehabilitation's credible allegation of compliance. We respectfully request a desk review. Preparation and /or execution of this plan of correction does not constitute admission or agreement	

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	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 483.90(a), Life Safety from Fire, the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building 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 installed in the resident rooms. The facility has a capacity of 88 and had a census of 18 at the time of this survey. All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinkled. A detached garage used for storage of maintenance equipment and parts, a detached sheds used for storage and another detached shed used for storage		by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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	of kitchen equipment were not sprinkled. Quality Review completed on 01/08/18 - DA			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 3 of 8 exit discharge paths maintained free of all obstructions to full use in case of emergency. This deficient practice could affect all residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 01/2/18 between 12:28 a.m. and 2:00 p.m., the exits discharge paths from the 100 hall, dining room, and lounge exits were obstructed with two to three inches of snow covering the entire path. Based on an interview at the time of observations, the Maintenance Director stated it snowed over the weekend and no one was available to shovel the sidewalks and agreed it has been	K 0211	It is the practice of this center to comply with K-211 NFPA 101 Life Safety Code. **What corrective actions(s) will be accomplished for those residents found to have been potentially affected by the deficient practice?** Snow, as identified by Surveyor and Maintenance Director on tour, was removed from pathways at each exit by Maintenance Director on 1/2/17. Education provided verbally to Maintenance Director on 1/2/17, and written format on 1/18/18, related to snow removal with respect to Life Safety Requirements and the Job Description expectation.	01/20/2018

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	at least two days since it snowed. 3.1-19(b)		**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 be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education provided verbally to Maintenance Director on 1/2/17, and written format on 1/18/18, related to snow removal policy and 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 put in place?** Maintenance Director, or designee, will document the date of new snowfall and date snow removal from sidewalks (this process will include ice melt being applied as needed and address snow removal at ½ inch or more in accumulation ASAP) on a weekly basis for 8 weeks, then every other week for 8 weeks, then monthly for 2 months.	

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			Audit findings will be presented to the QAA Committee monthly. Ongoing monitoring will continue Monthly per Preventive Maintenance Programing-TELS-Fire System. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas			

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	where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice was not in a resident care area but could affect staff outside the service hall exit. Findings include: Based on observation during a tour of the facility with Maintenance Director on 01/2/18 at 11:59 a.m., in and around the staff smoking area there were 7 cigarette butts on the ground. Based on interview at the time of observation, the Maintenance Director provided the quantity of cigarette butts and disposed of the butts that were on the ground. 3.1-19(b)	K 0741	It is the practice of this center to comply with K-741 NFPA 101 Smoking Regulations **What corrective actions(s) will be accomplished for those staff found to have been potentially affected by the deficient practice?** Cigarette butts found were immediately picked up and properly discarded. All staff education provided 1/18/18 as written format in communication area and will be provided as verbal format with next mandatory in-service, in January 2018. **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?** As this was not in a resident area, staff outside the service hall exit have the potential to be affected by this deficient practice. **What measures will be put into place or what systemic**	01/20/2018

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			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 next mandatory in-service, in January 2018. Facility to have designee to audit the staff smoking area and report issues to QAA, as described in the following response. **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?** Housekeeping Director, or Designee, will audit Staff Smoking Area 5 days a week x 8 weeks, then weekly x8 weeks, then monthly x2 to ensure staff are using the appropriate receptacle as provided to discard cigarette butts. Audit findings will be presented to the QAA Committee monthly. Ongoing monitoring will continue Monthly per Preventive Maintenance Programing-TELS-Fire System. The QAA Committee will review findings and determine the need	

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			for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips that were used for patient-care-related electrical equipment (PCREE) met UL 1363A or UL 60601-1 and 1 of 1 extension cords was not used as fixed wiring for	K 0920	It is the practice of this center to comply with K 920- NFPA 101 Electrical Equipment, Power Cord and Extension. **What corrective actions(s) will be accomplished for those**	01/20/2018

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	PCREE. This deficient practice could affect up to 2 residents in one room. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 01/2/18 at 1:19 p.m., in room 110 medical equipment that was currently used for a resident was plugged into and supplied power by a power strip that did not meet UL 1363A or UL 60601-1 and a second piece of medical equipment was plugged in an extension cord. Based on interview at the time of observations, the Maintenance Director agreed that PCREE was plugged into an extension cord and into a power strip that were not rated at UL 1363A or UL 60601-1. 3.1-19(b)		**residents found to have been potentially affected by the deficient practice?** Maintenance Director audited the 2 resident's room on 1/2/18, with respect to all items requiring the need to be plugged in to ensure the appropriate receptacle was in use. Facility preparing to move 1 of the 2 resident's to another room, thus enhancing privacy and allowing for improved access to power supply in relation to the individual needs of the resident. **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 be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education provided verbally to Maintenance Director on 1/2/17, and written format on 1/18/1, related to Electrical Equipment use and extension cords/power strips with respect to Life Safety	

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			Requirements and the Job Description expectation. Education Provided to Housekeeping Director on 1/18/18 on Life Safety Requirements to aid preparation for audits of extension cord and power strip use. **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?** Housekeeping Director, or Designee, will audit all resident occupied rooms weekly x8, then every other week x8, then monthly x2 to ensure that no extension cords or power strips are in use. Audit findings will be presented to the QAA Committee monthly. Ongoing monitoring Monthly per Preventive Maintenance Programing-TELS. The QAA Committee will review findings and determine the need for further monitoring and/or education per the QAA process. Compliance will be determined based on results of audits.	