STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. BUILDING -- B. WING	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN 46901

(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: 04/09/25 Facility Number: 000064 Provider Number: 155139 AIM Number: 100288770 At this Emergency Preparedness survey, North Woods Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 164 and had a census of 111 at the time of this survey. Quality Review completed on 04/14/25	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: 04/09/25 Facility Number: 000064 Provider Number: 155139 AIM Number: 100288770 At this Life Safety Code survey, North Woods Village was found not in compliance with Requirements for Participation in	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Head	Administrator	04/25/2025

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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	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 two 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 the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 164 and had a census of 111 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/14/25			
K 0211 SS=B Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to maintain 1 of 8 exit doors was free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could affect 40 on the 1st and 2nd flood that would use the Maple exit. Findings include: Based on observation with the Maintenance Director on 04/09/25 at 11:58 a.m., the Maple exit	K 0211	***This provider respectfully requests a desk review in lieu of a post-survey review on or after 5/15/25. Please feel free to contact the Executive Director, Stephanie Head, if you need any additional information to support the desk review at (765) 457-9175. Thank you for your consideration.*** ***Tag: K211- Facility failed to maintain 1 of 8 exit doors was free from impediments to full instant use in the case of fire or other emergency.*** ***What corrective action(s) will be***	05/15/2025

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	155139	A. BUILDING 01 B. WING	04/09/2025

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	door was equipped with panic hardware, but the door would not open on the first try. The Maintenance Director tried to open the door four times and the door opened on the fourth try. Based on an interview at 11:58 a.m., the Maintenance Director agreed it took excessive force to open the exit door due to a loose screw catching on the door. The Maintenance Director fixed the door and worked properly after repairs. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference at 1:30 p.m. 3.1-19(b)		***accomplished for those residents found to have been affected by the deficient practice? Door was found to have a loose screw catching the door, was immediately fixed and working properly.*** ***How will you identify other residents having the potential to be affected by the same deficient practice and what action will be taken? 8 of 8 exit doors checked for instant use in case of an emergency.*** ***What measures will be put into place or what systematic changes will you make to ensure that deficiency does not recur? Staff to be educated to need of exit doors to be free of impediments to ensure instant use and proper reporting of any issue to ensure 8 of 8 exit doors are free of impediments.*** ***How will the correction action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? LSC Plan of Correction QA tool will be utilized weekly x 4 weeks, then monthly x 6 months to ensure 8 of 8 exit doors are free of impediments. Life Safety Plan of Correction QA tool will be reviewed by ED with QAPI.*** ***Date of Compliance: 5/15/25***	
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 2 of 2 sprinklers in the 2nd floor shower room by the nurse's station were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 states any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 30 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 04/09/25 at 12:25 p.m., the two sprinkler heads in the 2nd floor shower room by the nurse's station were green and showed signs of corrosion. Based on an interview at 12:25 p.m., the Maintenance Director agreed the two sprinkler heads in the 2nd floor shower room by the nurse's station showed signs of corrosion and needed to be replaced. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference at 1:30 p.m. 3.1-19(b)	K 0353	***This provider respectfully requests a desk review in lieu of a post-survey review on or after 5/15/25. Please feel free to contact the Executive Director, Stephanie Head, if you need any additional information to support the desk review at (765) 457-9175. Thank you for your consideration.*** ***Tag: K353- Facility failed to ensure 2 of 2 sprinklers in the second-floor shower room were free of corrosion.*** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility contacted IEI and sprinkler head repairs to be completed by 5/15/25.*** ***How will you identify other residents having the potential to be affected by the same deficient practice and what action will be taken? Maintenance Director checked all sprinkler heads to ensure sprinkler heads are in good repair.*** ***What measures will be put into place or what systematic changes will you make to ensure that the deficiency does not recur? Staff education to be completed by 5/15/25.*** ***How will the correction action be monitored to ensure the deficient practice will not recur,***	05/15/2025

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			i.e., what quality assurance program will be put into place? Maintenance will complete visual sprinkler checks and complete the LSC QA tool monthly x 6 months to ensure sprinklers are free of corrosion. ED will review LSC QA tool as part of the ongoing facility QAPI program. ***Date of Compliance: 5/15/25***	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) in the lobby restroom was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 10 residents in the front lobby. Findings include: Based on observation with the Maintenance Director on 04/09/25 at 11:20 a.m., when the lobby restroom GFCI electric receptacle was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on an interview at 11:20 a.m., the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference at 1:30 p.m.	K 0511	***This provider respectfully requests a desk review in lieu of a post-survey review on or after 5/15/25. Please feel free to contact the Executive Director, Stephanie Head, if you need any additional information to support the desk review at (765) 457-9175. Thank you for your consideration.*** ***Tag: K511- Facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) in the lobby restroom was properly maintained for protection against electric shock.*** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Thermodyne replaced GFCI receptacle in the front public restroom with a new GFCI receptacle, tested its operation and is working***	04/14/2025

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	3.1-19(b)		***properly, completed on 4/14/25. How will you identify other residents having the potential to be affected by the same deficient practice and what action will be taken? GFCI receptacles checked throughout the building, found to be maintained and protected from electric shock with no further findings. What measures will be put into place or what systematic changes will you make to ensure that deficiency does not recur? Maintenance Director will check all GFCI to ensure properly maintained. How will the correction action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? LSC Plan of Correction QA tool will be utilized monthly x 6 months to ensure all ground fault circuit interrupters are maintained and there is no risk of electric shock. QA tool reviewed with QAPI meeting by ED. Date of Compliance: 4/14/25***	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension	K 0920	***This provider respectfully requests a desk review in lieu of a post-survey review on or after 5/15/25. Please feel free to***	05/15/2025

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	cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states that cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 04/09/25 at 11:32 a.m. and 12:01 p.m., in the activities room and room 110 had power strips used to power equipment, was not secured, and was dangling from the equipment on the wall. This condition could put stress on the power cord causing damage to the power cord. Based on an interview at 11:32 a.m. and 12:01 p.m., the Maintenance Director agreed the power strips were dangling, not secured, and stated the power strips will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference at 1:30 p.m. 3.1-19(b)		***contact the Executive Director, Stephanie Head, if you need any additional information to support the desk review at (765) 457-9175. Thank you for your consideration.*** ***Tag: K920- Facility failed to ensure 2 of 2 flexible cords were installed properly and used in a safe manor.*** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 2 of 2 flexible cords were secured and installed properly.*** ***Completed 4/9/25.*** ***How will you identify other residents having the potential to be affected by the same deficient practice and what action will be taken? Full facility check of all flexible cords in use was performed 4/15/25 with no further findings.*** ***What measures will be put into place or what systematic changes will you make to ensure that deficiency does not recur? Facility will complete staff education by 5/15/25.*** ***How will the correction action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance will utilize the LSC POC QA tool to ensure all***	

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			flexible cords are used in a safe manor weekly x4 weeks then monthly x 6 months to ensure all flexible cords are installed properly and safely. ED will review LSC POC QA tool with the ongoing facility QAPI program. ***Date of Compliance: 5/15/25***	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to maintain 1 of 1 complete documentation of inspections for Patient-Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the	K 0921	***This provider respectfully requests a desk review in lieu of a post-survey review on or after 5/15/25. Please feel free to contact the Executive Director, Stephanie Head, if you need any additional information to support the desk review at (765) 457-9175. Thank you for your consideration.*** ***Tag: K921- Facility failed to maintain 1 of 1 complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE)*** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Maintenance was in process of the completion of the PCREE documentation during LSC survey and completed it on 4/10/25.*** ***How will you identify other residents having the potential to be affected by the same***	04/10/2025

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	testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review with the Maintenance Director on 04/09/25 at 1:10 p.m., there was no documentation to show PCREE testing for all the electrical resident beds. Based on observation from 11:36 p.m. to 1:00 p.m., each resident room contained two electrical beds. Based on an interview at 1:10 p.m., the Maintenance Director stated PCREE testing documentation was not complete due to the PCREE testing for the beds just started and only had part of the 100-hall completed. This finding was reviewed with the Maintenance Director and the Director of Nursing during the exit conference at 1:30 p.m. 3.1-19(b)		***deficient practice and what action will be taken? Maintenance will maintain this documentation and complete it annually per the TELS requirement. What measures will be put into place or what systematic changes will you make to ensure that deficiency does not recur? PCREE will be completed annually and when new equipment is purchased. How will the correction action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? LSC Plan of Correction QA tool will be utilized annually to ensure PCREE documentation of inspections are complete. The LSC Plan of Correction QA tool will be reviewed with QAPI meeting by ED. Date of Compliance: 4/10/25***	