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	05/08/2024

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: 05/08/24 Facility Number: 000015 Provider Number: 155041 AIM Number: 100273750 At this Emergency Preparedness survey, Northwest Manor Health Care Center was found not 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 96. Quality Review completed on 05/10/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 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*	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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

Bryce Reagan | Administrator | 05/30/2024

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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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients 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 the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health			

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	and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the 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 review of "Disaster Plan" documentation dated 10/31/23 with the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on 05/08/24, subsistence needs documentation for the emergency preparedness program was incomplete. The emergency preparedness documentation did not address sewage and waste disposal during an emergency or disaster. Based on interview at the time of record review, the Administrator agreed emergency preparedness program documentation did not include subsistence needs for sewage and waste disposal during an emergency or disaster. These findings were reviewed with the Administrator and the Maintenance Director	E 0015	It is the intention of Northwest Healthcare Center to meet the subsistence needs for staff and residents during the activation of an emergency. **1 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The emergency preparedness plan was revised to address sewage and waste removal during an emergency. There were no residents affected by the identified deficiency. **2 2. 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 emergency preparedness plan was revised to address sewage and waste removal during an emergency. There were no residents affected by the identified deficiency. **3 3. What measures will be put in place or what systematic changes will be made to**	05/27/2024

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	during the exit conference.		**ensure that the deficient practice does not recur:** The Administrator/designee will review and update the emergency preparedness plan annually using an emergency preparedness checklist. **4 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:** The emergency preparedness plan will be reviewed and adjusted as needed yearly. Any changes or amendments will be reported in QAPI. An emergency preparedness checklist will be completed upon annual review and presented to the QAPI committee with an expected compliance of 100%. 5 **By what date the systemic changes will be completed:** 5/27/2024	
E 0022 SS=F Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).			

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	(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based review of "Disaster Plan" documentation dated 10/31/23 with the Administrator and the Maintenance Director during record review from	E 0022	**It is the intention of Northwest Healthcare Center to identify in facility policy and procedures a means to shelter in place for residents, staff and volunteers.** **1 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The policies and procedures in the facility emergency preparedness	05/27/2024

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	9:50 a.m. to 1:10 p.m. on 05/08/24, a policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility was not available for review. Based on interview at the time of record review, the Administrator agreed a shelter in place policy and procedure was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.		plan were amended to include sheltering in place. There were no residents, staff or volunteers affected by the identified deficiency. **2 2. 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 policies and procedures in the facility emergency preparedness plan were amended to include sheltering in place. There were no residents, staff or volunteers affected by the identified deficiency. **3 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** The Administrator/designee will review and update the emergency preparedness plan annually using an emergency preparedness checklist. **4 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:** The emergency preparedness plan will be reviewed and adjusted as needed yearly. Any changes or	

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			amendments will be presented in QAPI. An emergency preparedness checklist will be completed upon annual review and presented to the QAPI committee with an expected compliance of 100% 5 5. **By what date the systemic changes will be completed:** 5/27/2024	
E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the			

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	process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based review of "Disaster Plan" documentation dated 10/31/23 with the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on 05/08/24, the emergency preparedness plan for the facility did not include the use of volunteers in an emergency or other emergency staffing strategies. Based on interview at the time of record review, the Administrator	E 0024	**It is the intention of Northwest Healthcare Center to ensure policies and procedures are in place for the use of volunteers in an emergency.** **1 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The facility policies and procedures were amended to include the use of volunteers during an emergency. There were no residents affected by the deficiency identified. **2 2. How other resident having the potential to be affected by the same deficient**	05/27/2024

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	agreed the emergency preparedness documentation did not include a policy for the use of volunteers. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.		**practice will be identified and that corrective action(s) will be taken:** The facility policies and procedures were amended to include the use of volunteers during an emergency. There were no residents affected by the deficiency identified. **3 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** The facility policies and procedures were amended to include the use of volunteers during an emergency. **4 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:** The emergency preparedness plan will be reviewed and adjusted as needed yearly. Any changes or amendments will be presented in QAPI. An emergency preparedness checklist will be completed upon annual review and presented to the QAPI committee with an expected compliance of 100% **5. By what date the systemic changes will be completed:** 5/27/2024	

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E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the			

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	continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based review of "Disaster Plan" documentation dated 10/31/23 with the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on 05/08/24, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Based on interview at the time of record review, the Administrator stated they have verbal agreements with other facilities but agreed documentation of arrangements with other facilities was not available for review at the time of the survey. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.	E 0025	**It is the intention of Northwest Healthcare Center to maintain documented arrangements with other facilities to receive residents in the event of emergency evacuation.** **1 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The emergency preparedness plan was updated to include signed emergency transfer agreements with other facilities. **2 2. 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 emergency preparedness plan was updated to include signed emergency transfer agreements with other facilities. **3 3. What measures will be put in place or what systematic changes will be made to**	05/27/2024

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			ensure that the deficient practice does not recur: The Administrator/designee will review and update the emergency preparedness plan annually using an emergency preparedness checklist to verify arrangements with other facilities are in place. **4 5. 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 emergency preparedness plan will be reviewed and adjusted as needed yearly. Any changes or amendments will be reported in QAPI. An emergency preparedness checklist will be completed upon annual review and presented to the QAPI committee with an expected compliance of 100% **5. By what date the systemic changes will be completed:** 5/27/2024	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)			

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(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
	(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			

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	155041	A. BUILDING -- B. WING	05/08/2024

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	(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			

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	(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency			

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	plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.			

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	(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is			

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	exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next			

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	required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following	E 0039	**It is the intention of Northwest Healthcare Center to conduct exercises to test the emergency plan at least twice per year.** **1 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** A second emergency preparedness exercise will be completed by 6/7/2024 to maintain compliance of two facility exercises in twelve months. No residents were affected by the deficiency.	06/07/2024

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	the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan" documentation dated 10/31/23 with the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on 05/08/24, documentation regarding a second emergency preparedness exercise conducted within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator stated the facility activated their Covid-19 response due to an outbreak on 07/02/23 and documented the exercise but agreed documentation regarding a second exercise was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.		**2 2. 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:** A second emergency preparedness exercise will be completed by 6/7/2024 to maintain compliance of two facility exercises in twelve months. No residents were affected by the deficiency. **3 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Emergency plan testing is scheduled twice a year to ensure compliance with regulations. A full-scale exercise has been scheduled annually in July. A tabletop exercise has been scheduled annually in February. Both exercises have been added to the preventative maintenance binder. **4 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:** The Administrator will plan and direct emergency plan testing according to regulation. Two	

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			exercises will be scheduled and completed unless an actual natural or man-made emergency has required the activation of the emergency plan. Exercises will be documented, and results will be presented to QAPI committee upon completion to determine any changes in the facility emergency plan. Emergency plan testing has been added to the QAPI agenda to ensure compliance. 5 5. **By what date the systemic changes will be completed:** 6/7/2024	
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: 05/08/24 Facility Number: 000015 Provider Number: 155041 AIM Number: 100273750 At this Life Safety Code survey, Northwest 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.	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*	

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	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 96 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 05/10/24			
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 4 of over 60 corridor doors in the facility were free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, the inactive leaf in the	K 0200	**It is the intention of Northwest Healthcare Center to ensure all corridor doors are free from obstructions or impediments to full instant use in case of fire or other emergency.** **1 1. What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** Positive latching devices were	05/27/2024

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	corridor door set to the Administrator's Office, the Wing 1 Dining Room, the Wing 1 Conference Room and the Social Services Office by Room 167 was each equipped with a sliding bolt at the top of the door to latch the door into the door frame. The active leaf in the door set would only latch into the inactive leaf if the slide bolt was used on the door in the fully closed position. Based on interview at the time of the observations, the Maintenance Director agreed the inactive leaf in the corridor door sets was not positive latching and provided obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		installed on the doors identified. There were no residents affected by the identified deficiency. **2 2. 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:** Positive latching devices were installed on the doors identified. There were no residents affected by the identified deficiency. **3 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Checking and verifying the function of positive latching devices was added to the monthly preventative maintenance monitoring. **4 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:** The Administrator/Designee will complete an audit of the preventative maintenance binder to verify door latching system inspections are completed. The audit will be completed monthly for six months. Audit results will be reported to the QAPI committee until substantial compliance is	

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(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
			achieved. Substantial compliance will be achieved upon six consecutive months of 100% compliance. 5 5. **By what date the systemic changes will be completed:** 5/27/2024	
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 2 of 7 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Section 7.5.2.2.1 states hangings or draperies shall not be placed over exit doors or located so that they conceal or obscure any exit, unless otherwise provided in 7.5.2.2.2. This deficient practice could affect over 40 residents, staff and visitors if needing to exit to the outside of the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, the exit door to the outside of the facility by Room 142 and by Room 165 each had a curtain covering the window in the exit door. Based on interview at the time of the	K 0211	**It is the intention of Northwest Healthcare Center to ensure all means of egress are free from obstructions or impediments.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The shear curtain was removed from the window of the two exit doors identified during the survey. There were no residents affected by the deficiency. **2 How other resident having the potential to be affected by the same deficient practice will be identified and**	05/27/2024

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	155041	A. BUILDING 01 B. WING	05/08/2024

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	observations, the Maintenance Director agreed the aforementioned means of egress were not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency due to the curtains being hung on the exit door windows. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**that corrective action(s) will be taken:** The shear curtain was removed from the window of the two exit doors identified during the survey. There were no residents affected by the deficiency. **3 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/Designee will verify exit doors do not have obstructions or impediments weekly. The weekly task was added to the preventative maintenance log. **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:** The Administrator will verify preventative maintenance task with the Maintenance Director/Designee monthly for six months. The preventative maintenance log will be presented to the QAPI committee monthly for six months. Audit results will be reported to the QAPI committee until substantial compliance is achieved. Substantial compliance will be achieved upon six consecutive months of 100% compliance.	

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			5 **By what date the systemic changes will be completed:** 5/27/2024	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on record review, observation and interview; the facility failed to meet the clear width requirement for 2 of 7 corridors or met an exception per 19.2.3.4(4). LSC Section 19.2.3.4(4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include:	K 0232	**It is the intention of Northwest Healthcare Center to meet the clear width requirement in the hallway.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The stored items were removed from the hallway. The facility has ordered different medication and treatment carts to meet compliance. There were no residents affected by the deficiency. **2 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 stored items were removed	07/06/2024

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	Based on review of the "Fire Policy and Procedure" section of the "Disaster Plan" dated 10/31/23 with the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on 05/08/24, the health care occupancy fire safety plan addressed the relocation of wheeled equipment during a fire or similar emergency. Page 22 of the aforementioned documentation stated, "All wheeled equipment will be removed from the halls and placed in the nearest room NOT preventing a safe resident evacuation". Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, a wheeled linen cart was stored in the corridor outside Room 111. A crash cart was stored in the corridor outside Room 113. A Hoyer lift was stored in the corridor outside Room 121. The corridor outside the resident sleeping rooms measured 84 inches in width as measured with a measuring tape. The storage of the wheeled equipment in the corridor restricted the width in the path of egress to, respectively, 57 inches, 59 inches and 59 inches. Each of the measurements were made with a measuring tape where the wheeled equipment was being stored. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned wheeled equipment reduced the clear unobstructed corridor width of the corridor to less than 60 inches. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		from the hallway. The facility has ordered different medication and treatment carts to meet compliance. There were no residents affected by the deficiency. **3 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/designee will monitor corridors for obstructions weekly. The weekly task was added to the preventative maintenance log. Staff education was provided for the proper storage of items. **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:** The Administrator will verify preventative maintenance task with the Maintenance Director/Designee monthly for six months. The preventative maintenance log will be presented to the QAPI committee monthly for six months. Audit results will be reported to the QAPI committee until substantial compliance is achieved 5 **By what date the systemic changes will be completed:**	

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			7/6/2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 4 of over 11 hazardous areas such as combustible storage rooms/spaces (over 50	K 0321	**It is the intention of Northwest Healthcare Center to ensure that hazardous are separated**	05/27/2024

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	square feet), soiled linen/ trash collection rooms (exceeding 64 gallons) and boiler and fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, the following was noted: a. the corridor door to the Dialysis Storage Room by Room 167 was equipped with a self-closing device and a latching mechanism to latch the door into the door frame but the door failed to fully self-close and latch into the door frame when tested to close multiple times. The Dialysis Storage Room was greater than 50 square feet in size and was used to store combustible boxes and supplies. b. the corridor door set to the storage room by Room 153 was equipped with self-closing devices and latching mechanisms to latch the doors into the door frame, but the door set failed to fully self-close and latch into the door frame when tested to close multiple times. The storage room was greater than 50 square feet in size and was used to store combustible boxes and supplies. c. the corridor door to the Electrical Room by the Geriatrician's Office was equipped with a self-closing device and a latching mechanism to latch the door into the door frame but the door failed to fully self-close and latch into the door frame when tested to close multiple times. The Electrical Room contained one natural gas fired furnace. d. the corridor door to the Employees Only room by the Wing 1 nurse's station was equipped with		**from other spaces with self-closing or automatic closing doors.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The maintenance department corrected the self-closing and latching failure on all doors identified. No residents were affected by the identified deficiency. **2 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 maintenance department corrected the self-closing and latching failure on all doors identified. No residents were affected by the identified deficiency. **3 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/Designee will check the doors identified weekly for one month. After four weeks of compliance is obtained, monthly checks will resume as scheduled.	

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	a self-closing device and a latching mechanism to latch the door into the door frame but the door failed to fully self-close and latch into the door frame when tested to close multiple times. The Employees Only room contained one 96 gallon soiled linen cart and one 64 gallon soiled linen cart. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned four hazardous areas were not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**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:** The Maintenance Director/designee will check the self-closing or automatic closing devices on the identified doors weekly for one month. All doors checked are expected to have a 100% closure rate for 4 weeks. Weekly monitoring results will be presented to QAPI committee for review. Monthly monitoring will resume once establishing 4 weeks of 100% closure rate. 5 **By what date the systemic changes will be completed:** 5/27/2024	
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, 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			

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	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 observation and interview, the facility failed to ensure all kitchen exhaust system grease filters were installed correctly. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 6.1.1 states listed grease filters, listed baffles, or other listed grease removal devices for use with commercial cooking equipment shall be provided. Section 6.1.3 states mesh filters shall not be used unless evaluated as an integral part of a listed exhaust hood or listed in conjunction with a primary filter in accordance with UL 1046. This deficient practice could affect over three staff and visitors in the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, all kitchen exhaust system grease filters in the kitchen range hood exhaust system were mesh filters installed at an angle not less than 45 degrees from the horizontal. The kitchen range hood system was equipped with a drip tray. With mesh filters in place, grease would not drain to the installed drip tray. No documentation was noted on the kitchen range hood exhaust system or was available for review indicating the system was evaluated in accordance with UL 1046. Based on interview at the time of the observations, the Maintenance Director stated the kitchen exhaust system grease	K 0324	**It is the intention of Northwest Healthcare Center to ensure kitchen filters are installed correctly.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The correct kitchen exhaust filters were installed. There were no residents, staff or visitors affected. **2 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 correct kitchen exhaust filters were installed. There were no residents, staff or visitors affected. **3 What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Filter ordering information including size and type will be added to the preventative	05/27/2024

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	filters in the kitchen range hood exhaust system have always been mesh filters but agreed the installed kitchen range hood filters were not baffles. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		maintenance book. The maintenance Director and Dietary Manager were educated on the proper filters required. The Maintenance Director will be responsible for ordering kitchen exhaust filter replacements. The Maintenance Director/Designee will conduct monthly monitoring for 3 months and then quarterly ongoing to ensure proper filters and proper placement of exhaust filters **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:** The Maintenance Director/Designee will monitor kitchen exhaust filters every month for 3 months for proper filter and proper placement. Expected compliance is 100%, compliance less than 100% will be reported to the QAPI committee. After 3 months of 100% compliance, monitoring will be completed monthly as a preventative maintenance task. 5 **By what date the systemic changes will be completed:** 5/27/2024	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance			

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	Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff and visitors. Findings include: Based review of the fire alarm system inspection contractor's "Fire Alarm System Inspection" documentation dated 04/14/23 and 04/18/24 with the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on 05/08/24, visual semi-annual fire alarm system inspection documentation six months after	K 0345	**It is the intention of Northwest Healthcare Center to ensure the facility fire alarm system is maintained** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** A visual semi-annual inspection will be performed. No residents were affected. **2 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:** A visual semi-annual inspection will be performed. No residents were affected. **3 What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** The semi-annual visual inspection was completed in May and added	05/27/2024

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	04/14/23 was not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director agreed visual semi-annual inspection documentation for the facility's fire alarm system six months after 04/14/23 was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		to the preventative maintenance schedule six months after the annual inspection conducted by the contracted facility in April. Visual inspection is scheduled for October. **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:** The Maintenance Director or designee will meet with the Administrator monthly to verify scheduled inspections are completed monthly for six months. The results will be reported to the QAPI committee. Expected inspection completion compliance will be 100%. 5 **By what date the systemic changes will be completed:** 5/27/2024	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific			

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	areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure steel armover sprinkler pipes in 1 of 6 smoke compartments were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, at Section 9.2.3.5.1 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Mechanical Room containing the facility's water softeners. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, a 41 inch armover length of horizontal mounted steel sprinkler piping was unsupported in the Mechanical Room above the water softener. A sprinkler bracket was detached from the ceiling and was dangling from the armover length. The length of the unsupported armover was measured with a measuring tape. Based on interview at the time of the observations, the Maintenance Director agreed the sprinkler bracket for the armover length had become detached from the ceiling which caused	K 0351	**It is the intention of Northwest Healthcare Center to ensure the sprinkler components are installed and secured properly.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The identified sprinkler bracket was secured to the ceiling. No residents were affected by the identified deficiency. **2 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 identified sprinkler bracket was secured to the ceiling. No residents were affected by the identified deficiency. **3 What measures will be put in place or what systematic changes will be made to**	05/27/2024

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	the armover to be unsupported. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur:** Sprinkler installation and brackets were added to the visual semi-annual fire inspection. **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:** The Maintenance Director or designee will meet with the Administrator monthly to verify scheduled inspections are completed. The results will be reported to the QAPI committee. Expected inspection completion compliance will be 100%. 5 **By what date the systemic changes will be completed:** 5/27/2024	
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 secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			

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	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 1. Based on record review, observation and interview; the facility failed to ensure a full hydrostatic flush was performed on 1 of 1 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler: Report of Inspection" documentation dated 04/12/24 with the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on 05/08/24, the most recent internal pipe inspection was performed on 07/23/20. Review of the sprinkler system inspection contractor's	K 0353	**It is the intention of Northwest Healthcare Center to ensure the sprinkler system is maintained and inspected as required by NFPA.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** A hydrostatic flush is scheduled to begin on 8/5/2024. The sprinkler system riser's accelerator was inspected and will be replaced on 6/10/2024. The data cables were relocated to prevent resting on the sprinkler piping. The Maintenance Director/Designee will conduct weekly visual inspection to ensure sprinkler system pressures are within adequate levels and sprinkler system monitoring system is functioning. **2 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:** A hydrostatic flush is scheduled to begin on 8/5/2024. The sprinkler system riser's accelerator was inspected and will be replaced on	10/01/2024

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	"Sprinkler: Five Year Internal Pipe Inspection" documentation dated 07/23/20" indicated the "6 inch Tyco Model DPV-1 System needs flushed." Review of the sprinkler system contractor's "Invoice #: I67442" documentation dated 07/23/20 stated "Further Work Required: Send quote to flush 1 dry system. System was flushed in 2015". Based on interview at the time of record review, the Administrator stated he could not find the quote from the contractor dated 07/23/20 and flushing of the facility's automatic sprinkler system had not been performed on or after 07/23/20 most likely due to the Covid-19 pandemic. The Administrator and the Maintenance Director stated the sprinkler system is operable and would function properly if needed. The Administrator provided "Quote #: Q36684" documentation dated 04/12/24 from the sprinkler system contractor to "perform a complete dry pipe sprinkler system hydraulic flush". The Administrator also provided a letter from the sprinkler system contractor dated 05/08/24 which stated the contractor "has received approval for a complete dry pipe sprinkler system hydraulic flush on all sprinkler feed mains, cross mains and branch lines of the entire facility. We will remove internal debris (rust) that was found during internal pipe inspection". Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, the facility had one dry sprinkler system riser located in the closet in the kitchen. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility		6/10/2024. The data cables were relocated to prevent resting on the sprinkler piping. The Maintenance Director/Designee will conduct weekly visual inspection to ensure sprinkler system pressures are within adequate levels and sprinkler system monitoring system is functioning. **3 What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** The hydrostatic flush was updated on the facility's inspection schedule. The contracted company has placed the inspection in their automatic scheduling program. Riser gauge monitoring was added to the monthly inspection task. **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:** The Maintenance Director or designee will meet with the Administrator/designee monthly to verify scheduled inspections are completed. The results will be reported to the QAPI committee. Expected inspection completion compliance will be 100%. 5 **By what date the systemic**	

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	failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, the facility had one dry sprinkler system riser located in the closet in the kitchen. The air pressure gauge for the sprinkler system riser's accelerator read zero and the shutoffs for the accelerator were in the closed position indicating it was not operable. Based on interview at the time of the observations, the Maintenance Director agreed the accelerator for the facility's dry sprinkler system was not operable. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**changes will be completed:** 10/01/2024	

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	3. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Director of Nursing Office. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, white data cables were resting on two separate sections of horizontal sprinkler piping in the attic as observed from the attic access in the Director of Nursing Office. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler pipe locations were used to support non-system components. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1			

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	and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms in Wing 3 were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Wing 3 Therapy Room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, two separate corridor door sets serve as the entrance to the Wing 3 Therapy Room by Room 146. The corridor door set to the Therapy Room nearest Wing 3 nurse's station was not equipped with latching hardware on either door to latch the doors into the door frame. The inactive leaf in the corridor door set to the Therapy Room on the east side of the room was equipped with a slide bolt on the top of the door. The active leaf in the door set would only latch into the inactive leaf if the slide bolt was used on the door in the fully closed position. Based on interview at the time of the observations, the Maintenance Director stated the	K 0361	**It is the intention of Northwest Healthcare Center to ensure doors separating the therapy room is separated by a barrier capable of resisting the passage of smoke.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** Positive latching devices were installed on the therapy doors identified. There were no residents affected by the identified deficiency. **2 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:** Positive latching devices were installed on the therapy doors identified. There were no residents affected by the identified deficiency. **3 What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** Checking and verifying the function of positive latching devices was added to the monthly preventative maintenance monitoring.	05/27/2024

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	room had been converted from a dining room to a Therapy Room, he didn't know how long ago it was converted to a therapy room and agreed the corridor door sets to the Therapy Room were not equipped with a positive latching device on each door leaf to latch the door into the door frame. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**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:** The Administrator/Designee will complete an audit of the preventative maintenance binder to verify door latching system inspections are completed. The audit will be completed monthly for six months. Audit results will be reported to the QAPI committee until substantial compliance is achieved. Substantial compliance will be achieved upon six consecutive months of 100% compliance. 5 **By what date the systemic changes will be completed:** 5/27/2024	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by			

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	CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 60 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, the ceiling mounted track	K 0363	**It is the intention of Northwest Healthcare Center to ensure that corridor doors are not impeded from closing and latching into their door frame.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The privacy curtain track was	05/27/2024

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	for the privacy curtain for the resident bed nearest the corridor door was installed such that the privacy curtain was in the path of the swing of the corridor door to resident Room 166. The privacy curtain was in the fully opened position in the room and prevented the corridor door from fully closing and latching into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the privacy curtain in Room 166 was in the path of the swing of the corridor door to the room and would not ensure the door would close and latch into the door frame. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		moved to allow the door to be closed without the privacy curtain impeding closure. **2 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 privacy curtain track was moved to allow the door to be closed without the privacy curtain impeding closure. **3 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/designee will check corridor door closures monthly. **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:** The Administrator/designee will audit preventative maintenance binder monthly for six months to verify door latching system inspections are completed. Administrator/designee will round with maintenance department to verify random door closure and latching monthly for three months. The Administrator and	

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			maintenance department round results will be presented in QAPI. Door closure and latching audits will be expected to be 100%. 5 **By what date the systemic changes will be completed:** 5/27/2024	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle	K 0914	**It is the intention of Northwest Healthcare Center to ensure documentation of electrical**	05/31/2024

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	testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Administrator and the Maintenance Director from 9:50 a.m. to 1:10 p.m. on 05/08/24, electrical receptacle inspection and testing documentation for all resident sleeping rooms within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director agreed electrical receptacle inspection and testing documentation for all resident sleeping rooms for the most recent		**outlet receptacle testing for all resident rooms.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The maintenance department labeled resident room receptacle outlets. An annual test was completed on each resident room receptacle. **2 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 maintenance department labeled resident room receptacle outlets. An annual test was completed on each resident room receptacle. **3 What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur:** A receptacle testing flowsheet was added to the preventative maintenance binder. Each resident room receptacle was identified and tested. Each resident room receptacle was scheduled for routine annual inspection. **4 How the corrective**	

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	twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, all resident sleeping rooms had non-hospital-grade receptacles installed in the rooms. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**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 Administrator/designee will audit preventative maintenance binder monthly for six months to review receptacle testing completed. The process and results will be reviewed by the QAPI committee. 5 **By what date the systemic changes will be completed:** 5/31/2024	
K 0920 SS=E 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155041	A. BUILDING 01 B. WING	05/08/2024

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	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 3 of 3 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance	K 0920	**It is the intention of Northwest Healthcare Center to ensure that extension cords and power strips are not used as a substitute for fixed wiring.** **1 What corrective action(s) will be accomplished to those residents found to have been affected by the deficient practice:** The extension cord and power strip identified were removed. No resident was affected by the identified deficiency. **2 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:** A facility search did not find any other extension cord or power strip being used as a substitute for fixed wiring. **3 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/designee will conduct weekly rounds to identify extension cords or power strips	05/27/2024

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	Director during a tour of the facility from 1:10 p.m. to 3:20 p.m. on 05/08/24, a CPAP machine and two cell phone charging cables were plugged into a power strip placed on top of a table within one foot of the resident bed nearest the corridor door in resident sleeping Room 138. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Maintenane Director agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and was also being used as a substitute for fixed wiring at the aforementioned location. In addition, an extension cord was plugged into a power strip placed on the floor for a laptop computer on top of an employee's desk in the Therapy Room. The Maintenance Director agreed the extension cord and power strip were being used as a substitute for fixed wiring in the Therapy Room. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		being used out of compliance. Once four weeks of 100% compliance is achieved, monitoring will be completed ongoing monthly. **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:** The Maintenance Director/designee will conduct weekly rounds to identify extension cords or power strips being used out of compliance. Weekly rounds will be conducted for four weeks. After four weeks of 100% compliance, rounds will be conducted monthly ongoing. Monthly rounds will be reviewed with the Administrator/designee monthly. Results to be reported to the QAPI committee. Expected compliance is 100%. 5 **By what date the systemic changes will be completed:** 5/27/2024	