STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		A. BUILDING COM			(X3) DATE (COMPL 05/08/	ETED	
	IDER OR SUPPLIER	LTH CARE CENTER		6440 W	ADDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG E 0000	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg An con acc Sur Fac Pro AIM At No: not Rec Par 483 The the Quart The ME E 0015 403 SS=F (1), Bldg 485 Sul	nducted by the Incordance with 42 rvey Date: 05/08 cility Number: 05/08 cility Number: 100 pointer Number: 1 M Number: 1002 this Emergency I orthwest Manor H tin compliance with tin compliance with tin compliance with ting Provided 3.73. The facility has 126 exercises a survey, the censular transfer of the survey, the censular transfer of the survey	200015 155041 273750 Preparedness survey, ealth Care Center was found rith Emergency Preparedness fedicare and Medicaid ers and Suppliers, 42 CFR certified beds. At the time of us was 96. hpleted on 05/10/24 42 CFR, Subpart 483.73 is NOT	E 00	000	Preparation and or execution of this plan of correction does not constitute admission or agreed by the provider of the truth of the facts alleged or conclusions so forth in the statement of deficiencies. The plan of correction is prepared and/or executed because it is require the provisions of federal and so law	t ment the et d by	
§48 [(b) mu pre on	83.73(b)(1), §48) Policies and pust develop and eparedness policithe emergency	160.84(b)(1), §482.15(b)(1), §3.475(b)(1), §485.625(b)(1) Procedures. [Facilities] implement emergency cies and procedures, based plan set forth in paragraph			TITLE		(X6) DATE

(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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	OF CORRECTION	IDENTIFICATION NUMBER 155041		UILDING	nstruction 	COMPL 05/08/	ETED
	PROVIDER OR SUPPLIER	LTH CARE CENTER		6440 W	DDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE CROSS-REFERENCE)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(a) of this section, paragraph (a)(1) of communication played section. The policible reviewed and use [annually for LTC] the policies and put the following: (1) The provision of staff and patients shelter in place, in	risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated every 2 years facilities]. At a minimum, rocedures must address of subsistence needs for whether they evacuate or iclude, but are not limited					
	supplies (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision						
	(B) Emergency lig (C) Fire detection, systems. (D) Sewage and v	extinguishing, and alarm					
	Policies and proce (6) The following a for hospice-operat	are additional requirements ted inpatient care facilities and procedures must					
	(iii) The provision hospice employee they evacuate or sare not limited to t (A) Food, water, n supplies. (B) Alternate sound the following:	of subsistence needs for es and patients, whether shelter in place, include, but he following: nedical, and pharmaceutical ces of energy to maintain					
	the following:	to protect patient health					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SUF	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETI	
		155041	B. W	ING		05/08/20	24
NAME OF P	PROVIDER OR SUPPLIEF		•		ADDRESS, CITY, STATE, ZIP COD	•	
NORTHV	VEST MANOR HEA	ALTH CARE CENTER			/ 34TH ST IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	C C	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and safety and for	the safe and sanitary					
	storage of provision	ons.					
	(2) Emergency lighting.(3) Fire detection, extinguishing, and alarm systems.						
	(C) Sewage and v						
		view and interview, the facility	E 0	015	It is the intention of Northwest	Ŭ	5/27/2024
		ergency preparedness policies			Healthcare Center to meet the		
	_	ude at a minimum, (1) The			subsistence needs for staff ar	-	
	1 ^	ence needs for staff and			residents during the activation	of	
		hey evacuate or shelter in			an emergency.		
	l •	are not limited to the following:				,,	
	1 ' '	dical, and pharmaceutical			1 1. What corrective action		
	supplies. (ii) Alternate sources of energy to				will be accomplished to thos		
		peratures to protect resident			residents found to have been	n	
	· ·	nd for the safe and sanitary			affected by the deficient		
		ns; (B) Emergency lighting; (C)			practice:		
		nguishing, and alarm systems;			The emergency preparedness	-	
		d waste disposal in accordance 3(b)(1). This deficient practice			was revised to address sewag	je	
	could affect all occi				and waste removal during an		
	could affect all occi	upants.			emergency. There were no residents affected by the iden	tified	
	Findings include:				deficiency.	uneu	
	i mamga merade.				denoieriey.		
	Based review of "D	isaster Plan" documentation			2 2. How other resident		
	dated 10/31/23 with	the Administrator and the			having the potential to be		
	Maintenance Direct	tor during record review from			affected by the same deficie	nt	
	9:50 a.m. to 1:10 p.	m. on 05/08/24, subsistence			practice will be identified and		
	needs documentation	on for the emergency			that corrective action(s) will	be	
	preparedness progra	am was incomplete. The			taken:		
		dness documentation did not			The emergency preparedness	s plan	
		l waste disposal during an			was revised to address sewag	ge	
		ter. Based on interview at the			and waste removal during an		
		ew, the Administrator agreed			emergency. There were no		
		dness program documentation			residents affected by the iden	tified	
		sistence needs for sewage and			deficiency.		
	waste disposal duri	ng an emergency or disaster.					
					3 3. What measures will be	- I	
	These findings were				put in place or what systema	atic	
	Administrator and t	he Maintenance Director			changes will be made to		

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	OF CORRECTION	IDENTIFICATION NUMBER 155041	A. BUILDING B. WING	JNSTRUCTION 	COME	E SURVEY PLETED 3/2024
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP / 34TH ST IAPOLIS, IN 46224	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	during the exit confe	erence.		ensure that the deficient review and update the preparedness plan are an emergency preparechecklist. 4	cur: signee will e emergency nually using redness ective nitored to practice hat quality will be put aredness plan adjusted as hanges or reported in sist will be ual review and PI committee npliance of	
E 0022 SS=F Bldg	441.184(b)(4), 482 483.73(b)(4), 485. 485.727(b)(2), 485 494.62(b)(3) Policies/Procedure §403.748(b)(4), §4 (i), §441.184(b)(4) (4), §483.73(b)(4), (2), §485.625(b)(4	6.54(b)(3), 418.113(b)(6)(i), 6.15(b)(4), 483.475(b)(4), 625(b)(4), 485.68(b)(2), 6.920(b)(3), 491.12(b)(2), es for Sheltering in Place 6.16.54(b)(3), §418.113(b)(6), §460.84(b)(5), §482.15(b) §483.475(b)(4), §485.68(b), 9, §485.727(b)(2), 191.12(b)(2), §494.62(b)(3)				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUIL	LDING	NSTRUCTION	(X3) DATE COMPL	ETED
		155041	B. WING	G	_	05/08/	/2024
	PROVIDER OR SUPPLIEF	ALTH CARE CENTER		6440 W	ADDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	must develop and preparedness police on the emergency (a) of this section, paragraph (a)(1) communication placetion. The policible reviewed and development of the policies and process the follow [(4) or (2),(3),(5),(1) place for patients, remain in the [faction of the policies and process and process the follow (i) A means to she hospice employed hospice. Based on record revisited to ensure emand procedures included to ensure emand procedures included for residents, staff, the LTC facility in 483.73(b)(4). This concupants. Findings include: Based review of "Didated 10/31/23 with displacements of the policies and procedures included to the policies and procedures included to ensure emand procedures included to the policies and procedures included to ensure emand procedures emand procedures included to ensure emand procedures included to ensure emand procedures included to ensure emand procedures emand procedures included to ensure emand procedures included to ensure emand procedures em	6)] A means to shelter in staff, and volunteers who lity]. spices at §418.113(b):] edures. are additional requirements ted inpatient care facilities and procedures must	E 002	22	It is the intention of Northwe Healthcare Center to identify facility policy and procedure means to shelter in place for residents, staff and voluntee 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 facility emergency preparedness.	r in is a a a a a a a a a a a a a a a a a a	05/27/2024

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/08/2024
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440	r address, city, state, zip cod W 34TH ST NAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
TAG	9:50 a.m. to 1:10 p. procedure that incluplace for residents, remain in the LTC freview. Based on it review, the Administration and procedure. These findings were	m. on 05/08/24, a policy and ded a means to shelter in staff, and volunteers who facility was not available for atterview at the time of record strator agreed a shelter in place was not available for review.	TAG	plan were amended to include sheltering in place. There wer residents, staff or volunteers affected by the identified deficiency. 2 2. How other resident having the potential to be affected by the same deficie practice will be identified an that corrective action(s) will taken: The policies and procedures if facility emergency preparedne plan were amended to include sheltering in place. There were residents, staff or volunteers affected by the identified deficiency. 3 3. What measures will be put in place or what systems changes will be made to ensure that the deficient practice does not recur: The Administrator/designee were view and update the emerging preparedness plan annually update the process affected by the identification of the practice does not recur:	nt d be in the less less less less less less less le
				an emergency preparedness checklist. 4	
				will not recur, i.e., what qual assurance program will be prin place: The emergency preparedness will be reviewed and adjusted needed yearly. Any changes of the control o	ity out s plan as

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	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/08/2024	
		6440 W	V 34TH ST	OD	
4) ID SUMMARY STATEMENT OF DEFICIENCIE LEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION DATE	
			QAPI. An emergency preparedness checklist completed upon annual presented to the QAPI with an expected comp 100% 5 5. By what date to	t will be al review and committee bliance of	
441.184(b)(6), 484 483.73(b)(6), 484 485.68(b)(4), 485 491.12(b)(4), 494 Policies/Procedur §403.748(b)(6), § §441.184(b)(6), § §485.68(b)(4), §4 §485.920(b)(5), §4 [(b) Policies and preparedness polion the emergency (a) of this section, paragraph (a)(1) ocommunication placetion. The policies reviewed and uperse [annually forminimum, the poliaddress the follow (6) [or (4), (5), or (of volunteers in an	2.15(b)(6), 483.475(b)(6), .102(b)(5), 485.625(b)(6), .727(b)(4), 485.920(b)(5), .62(b)(5) es-Volunteers and Staffing .416.54(b)(5), §418.113(b)(4), .460.84(b)(7), §482.15(b)(6), .83.475(b)(6), §484.102(b)(5), .85.625(b)(6), §485.727(b)(4), .491.12(b)(4), §494.62(b)(5). Procedures. The [facilities] Implement emergency cies and procedures, based of plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a cies and procedures must or this section and procedures must of this section are the section and procedures must of this section are the section and procedures must of this section are the section and procedures must of this section are the section are the section and procedures must of the section are				
	SUMMARY (EACH DEFICIENT REGULATORY OF STATE OF S	OF CORRECTION IDENTIFICATION NUMBER 155041 PROVIDER OR SUPPLIER VEST MANOR HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	## A. BUILDING B. WING PROVIDER OR SUPPLIER	DENTIFICATION NUMBER 155041 DENTIFICATION NUMBER VEST MANOR HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIE (FACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION AMERICAN AMERICAN	DEFORMED TO SUPPLIER PROVIDER OR SUPPLIER WEST MANOR HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ID OATE MANUAL STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ID OATE Manual State of the Capture of the C

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED
		155041	B. WING		05/08/2024
			CTDE	ET ADDRESS OF VICTATE ZID COD	
NAME OF 1	PROVIDER OR SUPPLIEF	2		ET ADDRESS, CITY, STATE, ZIP COD	
NODTU		ALTH CARE CENTER) W 34TH ST	
NORTH	WEST MANOR HEA	ALTH CARE CENTER	וטאוו	ANAPOLIS, IN 46224	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		LD BE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	process and role	for integration of State and			
	Federally designa	ted health care			
	professionals to a	ddress surge needs during			
	an emergency.				
	*[For RNHCIs at §	403.748(b):] Policies and			
	procedures. (6) TI	he use of volunteers in an			
	emergency and o	ther emergency staffing			
	strategies to addr	ess surge needs during an			
	emergency.				
	*[For Hospice at §418.113(b):] Policies and				
	procedures. (4) T	he use of hospice			
	employees in an e	emergency and other			
	emergency staffin	g strategies, including the			
	process and role	for integration of State and			
	Federally designa	ted health care			
	professionals to a	ddress surge needs during			
	an emergency.				
	Based on record rev	view and interview, the facility	E 0024	It is the intention of Nor	thwest 05/27/2024
	failed to ensure em	ergency preparedness policies		Healthcare Center to en	sure
	and procedures incl	ude the use of volunteers in		policies and procedures	are in
	an emergency or of	her emergency staffing		place for the use of volu	inteers
		g the process and role for		in an emergency.	
	_	or Federally designated health			
	•	o address surge needs during		1 1. What corrective	
		cordance with 42 CFR		action(s) will be accomp	olished
		deficient practice could affect		to those residents found	i to
	all occupants.			have been affected by the	ne
				deficient practice:	
	Findings include:			The facility policies and	
				procedures were amende	
		isaster Plan" documentation		include the use of volunte	ers
		n the Administrator and the		during an emergency. Th	ere were
	Maintenance Direct	tor during record review from		no residents affected by t	he
		m. on 05/08/24, the emergency		deficiency identified.	
	preparedness plan f	or the facility did not include			
	the use of volunteer	rs in an emergency or other		2 2. How other reside	ent

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emergency staffing strategies. Based on interview

at the time of record review, the Administrator

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having the potential to be

affected by the same deficient

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	r í	UILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
NORTHW	VEST MANOR HEA	LTH CARE CENTER			APOLIS, IN 46224	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
TAG	agreed the emergen documentation did not volunteers. This finding was re-			TAG	practice will be identified an that corrective action(s) will taken: The facility policies and procedures were amended to include the use of volunteers during an emergency. There is no residents affected by the deficiency identified. 3 3. What measures will be put in place or what systems 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 qual assurance program will be prin place: The emergency preparedness will be reviewed and adjusted needed yearly. Any changes of amendments will be presented QAPI. An emergency preparedness checklist will be completed upon annual review presented to the QAPI commit with an expected compliance 100% 5. By what date the systemic changes will be completed:	d be Were o e atic o e atic o e atic o e atic o e atic o e atic o e atic o e atic o e atic o e atic o e
					5/27/2024	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	CON	TE SURVEY MPLETED 08/2024
	PROVIDER OR SUPPLIEF	ALTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP C / 34TH ST IAPOLIS, IN 46224	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 0025 SS=F Bldg	482.15(b)(7), 483 485.625(b)(7), 48 Arrangement with §403.748(b)(7), § (7), §460.84(b)(8 (7), §483.475(b)(7), §485.920(b)(6), §	418.113(b)(5), §441.184(b)), §482.15(b)(7), §483.73(b) 7), §485.625(b)(7), 494.62(b)(6).				
	must develop and preparedness pol on the emergency (a) of this section, paragraph (a)(1) communication pl section. The polic be reviewed and uyears [annually fo	procedures. The [facilities] implement emergency icies and procedures, based in plan set forth in paragraph irisk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 ir LTC facilities]. At a icies and procedures must iving:]				
	§441.184,(b) Hos LTC Facilities at § procedures. (7) [o arrangements with other providers to of limitations or ce	§418.113(b), PRFTs at pitals at §482.15(b), and §483.73(b):] Policies and or (5)] The development of h other [facilities] [and] receive patients in the event essation of operations to nuity of services to facility				
	§483.475(b), CAF at §485.920(b) an §494.62(b):] Polic (6), (8)] The deve with other [facilities receive patients in	60.84(b), ICF/IIDs at Is at §486.625(b), CMHCs Id ESRD Facilities at ies and procedures. (7) [or lopment of arrangements ies] [or] other providers to in the event of limitations or				

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Facility ID: 000015

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETE	D
		155041	B. W	ING		05/08/202	24
	PROVIDER OR SUPPLIER	ALTH CARE CENTER	•	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CO	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	continuity of servi	ces to facility patients.					
	*[For RNHCIs at § procedures. (7) The arrangements with providers to receive limitations or cess maintain the continuous services to RNHC Based on record reversal failed to ensure emergements with a providers to receive limitations or cessar the continuity of set accordance with 42 deficient practice of the continuity of set accordance with 42	Ado3.748(b):] Policies and the development of an other RNHCls and other we patients in the event of station of operations to unuity of non-medical all patients. Where are included the development of other LTC facilities and other excited the development of other LTC facilities and other excited the development of other LTC residents in CFR 483.73(b)(7). This ould affect all occupants. Administrator and the tor during record review from m. on 05/08/24, documentation are development of other LTC facilities and other excited the devel	E 00	025	It is the intention of Northwe Healthcare Center to maintaid documented arrangements with other facilities to receiv 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 was updated to include signed emergency transfer agreemer with other facilities. 2 2. How other resident having the potential to be affected by the same deficien practice will be identified and that corrective action(s) will taken: The emergency preparedness was updated to include signed emergency transfer agreemer with other facilities. 3 3. What measures will be put in place or what systematics.	e ed	5/27/2024
					1	ntic	
	during the exit conf	erence.	I		changes will be made to		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULT A. BUILD B. WING	DING	NSTRUCTION	(X3) DATE COMPL 05/08/	ETED
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6	440 W	DDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					ensure that the deficient practice does not recur: The Administrator/designee was review and update the emergon preparedness plan annually under an emergency preparedness checklist to verify arrangement with other facilities are in placed. 4 5. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be prin place: The emergency preparedness will be reviewed and adjusted needed yearly. Any changes of amendments will be reported QAPI. An emergency preparedness checklist will be completed upon annual review presented to the QAPI comming with an expected compliance 100% 5. By what date the systemic changes will be completed: 5/27/2024	ency sing its e. o ity out as plan as or in e w and ittee of	
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 49° EP Testing Requir §416.54(d)(2), §4° §460.84(d)(2), §4° §483.475(d)(2), §4°	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 184.102(d)(2), §485.68(d)(2), 185.727(d)(2), §485.920(d)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLETED D. S/08/2024			
		155041	B. WING		05/08/2024	
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD		
				W 34TH ST		
NORTHV	VEST MANOR HEA	ALTH CARE CENTER	INDIA	NAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	PRIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	(2), §491.12(d)(2)	, §494.62(d)(2).				
	*IFor ASCo at \$44	6.54. CODEs at \$495.69				
		6.54, CORFs at §485.68, ons" under §485.727,				
		20, RHCs/FQHCs at				
	_	RD Facilities at §494.62]:				
	3481.12, aliu ESF	ND 1 aciiilies al 3434.02].				
	(2) Testing. The [f	acility] must conduct				
		he emergency plan				
		ility] must do all of the				
	following:					
	(i) Participate in a full-scale exercise that is					
	community-based every 2 years; or					
	1 ' '	nunity-based exercise is				
		nduct a facility-based				
		e every 2 years; or				
	, , -	lity] experiences an actual				
		ade emergency that requires				
		mergency plan, the [facility]				
	-	gaging in its next required				
	1 -	or individual, facility-based				
	actual event.	e following the onset of the				
		ditional exercise at least				
	1 ' '	posite the year the full-scale				
		cise under paragraph (d)(2)				
		s conducted, that may				
	1 ''	limited to the following:				
		scale exercise that is				
	1 ' '	or individual, facility-based				
	functional exercise					
	(B) A mock disast					
	1 ' '	ercise or workshop that is				
	1 ' '	and includes a group				
	discussion using a	- .				
	_	emergency scenario, and a				
	set of problem sta	-				
	1	pared questions designed				
	to challenge an er	·				

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	N OF CORRECTION	IDENTIFICATION NUMBER 155041	l í	JILDING		COMPL 05/08/	ETED
NAME O	F PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD 34TH ST		
NORTH	HWEST MANOR HEA	ALTH CARE CENTER		INDIAN	APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(iii) Analyze the [fa maintain documen exercises, and en the [facility's] eme *[For Hospices at (2) Testing for hothe patient's home conduct exercises plan at least annuathe following: (i) Participate in a community based (A) When a commaccessible, conduct based functional (B) If the hospice man-made emergency exempt from engascale community-facility-based functional exercise of the emer (ii) Conduct an advears, opposite the functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exeled by a facilitator discussion using a clinically-relevant set of problem states.	acility's] response to and natation of all drills, tabletop nergency events, and revise rgency plan, as needed. 418.113(d):] spices that provide care in e. The hospice must is to test the emergency ally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not let an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual stional exercise following the gency event. Inditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041 B. WING		(X3) DATE SURVEY COMPLETED 05/08/2024				
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEF	₹			' 34TH ST		
NORTHV	WEST MANOR HEA	ALTH CARE CENTER	ı	INDIAN	APOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCT		DATE
	. ,	spices that provide inpatient hospice must conduct					
	1	he emergency plan twice					
		spice must do the following:					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
	, ,	ıct an annual individual					
	facility-based fund	ctional 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						
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	· '	dditional annual exercise					
	-	but is not limited to the					
	following:	and aversion that in					
	' '	-scale exercise that is I or a facility based					
	functional exercise						
	(B) A mock disas						
	, ,	ercise or workshop led by a					
	. ,	udes a group discussion					
	using a narrated,						
	_	irio, and a set of problem					
		ted messages, or prepared					
		ed to challenge an					
	emergency plan.						
		nospice's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the hospice's eme	ergency plan, as needed.					
	*IFor PRFTs at 8/	141.184(d), Hospitals at					
	§482.15(d), CAHs						
	· ,,	PRTF, Hospital, CAH] must					
		s to test the emergency					

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPLETED	
		155041	B. W	ING	_	05/08/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIEI	₹			34TH ST		
NORTH\	WEST MANOR HEA	ALTH CARE CENTER			APOLIS, IN 46224	<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		Ν
TAG	1	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		ar. The [PRTF, Hospital,					
	CAH] must do the	•					
		an annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ıct an annual individual,					
		ctional exercise; or					
		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.						
	1 ' '	an [additional] annual					
		nat may include, but is not					
	limited to the follo	_					
		-scale exercise that is					
	community-based						
	1	ctional exercise; or					
	` '	ock disaster drill; or					
		p exercise or workshop that					
	1	tor and includes a group					
	discussion, using						
	1	emergency scenario, and a					
		itements, directed					
		pared questions designed					
	to challenge an e						
	, ,	he [facility's] response to					
		umentation of all drills,					
	1	s, and emergency events					
	and revise the [fa	cility's] emergency plan, as					
	needed.						
	*[For PACE at §4	60.84(d):]					
	-	PACE organization must					
	conduct exercises to test the emergency						
	plan at least annu	9 3					
	organization must	-					
	_	an annual full-scale exercise					

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	AN OF CORRECTION	IDENTIFICATION NUMBER 155041	A. BUI B. WIN	LDING		COMPL 05/08/	ETED
	DF PROVIDER OR SUPPLIER HWEST MANOR HEA	ALTH CARE CENTER		6440 W	DDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	accessible, condu- facility-based function (B) If the PACE ex- or man-made ema- activation of the exist exempt from en- full-scale community-based functional exercises of this section is community-based functional exercises of this section is community-based based functional exercises (C) A tabletop ex- led by a facilitator discussion, using clinically-relevant set of problem star messages, or pre- to challenge an en- (iii) Analyze the F- maintain document exercises, and en- the PACE's emergency *[For LTC Facilities (2) The [LTC facilities (2) The [LTC facilities (2) The [LTC facilities (2) The ILTC facilities (3) The ILTC facilities (4) The ILTC facilities (5) The ILTC facilities (6) The ILTC facilities (7) The ILTC facilities (8) The ILTC facilities (9) The ILTC facilities (10) The ILTC facilities (11) The ILTC facilities (12) The ILTC facilities (13) The ILTC facilities (14) The ILTC facilities (15) The ILTC facilities (16) The ILTC facilities (17) The ILTC facilities (17) The ILTC facilities (18) IN PACE of the PACE of	nunity-based exercise is not act an annual individual, etional exercise; or experiences an actual natural ergency that requires mergency plan, the PACE agaging in its next required nity based or individual, etional exercise following the gency event. In additional exercise every the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is for individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. PACE's response to and entation of all drills, tabletop nergency events and revise gency plan, as needed. Les at §483.73(d):] ity] must conduct exercises ency plan at least twice per announced staff drills using occedures. The [LTC facility, the following: an annual full-scale exercise					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155041 B. WING		COM	(X3) DATE SURVEY COMPLETED 05/08/2024			
	PROVIDER OR SUPPLIEI	ALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLETION DATE	
	(A) When a commaccessible, condufacility-based functional facility-based functional facility-based functional facility-based functional facility-based functional following the onset (ii) Conduct an act that may include, following: (A) A second full-community-based functional following: (A) A second full-community-based functional following: (B) A mock disast (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem star messages, or preto challenge an el (iii) Analyze the [I response to and rall drills, tabletop events, and revise emergency plan, and the following: (C) Testing. The following: (I) Participate in a that is community (A) When a community (A) When a community (A) When a community (B) the following is the facility of the following in a that is community (A) When a community (B) When (B)	nunity-based exercise is not act an annual individual, ctional exercise. cility] facility experiences an anan-made emergency that a of the emergency plan, the mpt from engaging its next ale community-based or based functional exercise at of the emergency event. Additional annual exercise but is not limited to the escale exercise that is a or an individual, facility exercise; or ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency et the [LTC facility] facility's as needed. 6483.475(d)]: CF/IID must conduct the emergency plan at least are ICF/IID must do the					

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facility-based functional exercise; or.

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION X3) I		(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u></u>	COMPLETED	
		155041	B. WING		05/08/2024	
NAME OF I	DROVIDED OD CUDDI IEI		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF		6440 W	/ 34TH ST		
NORTHV	NORTHWEST MANOR HEALTH CARE CENTER		INDIAN	APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	` '	experiences an actual				
		ade emergency that requires				
		mergency plan, the ICF/IID				
	•	gaging in its next required				
		nity-based or individual,				
		tional exercise following the				
	onset of the emer	-				
	' '	ditional annual exercise				
	_	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					
		ercise or workshop that is				
		and includes a group				
	discussion, using					
	set of problem sta	emergency scenario, and a				
		pared questions designed				
	to challenge an er	·				
	_	CF/IID's response to and				
		ntation of all drills, tabletop				
		nergency events, and revise				
		rgency plan, as needed.				
		gone, plan, as nesded.				
	*[For HHAs at §48	34.102]				
	(d)(2) Testing. The	e HHA must conduct				
	exercises to test t	he emergency plan at				
	least annually. Th	e HHA must do the				
	following:					
	(i) Participate in a	full-scale exercise that is				
	community-based	; or				
	(A) When a c	ommunity-based exercise				
	is not accessible, conduct an annual individual, facility-based functional exercise					
	every 2 years; or.					
	(B) If the HH	A experiences an actual				
	natural or man-ma	ade emergency that requires				

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activation of the emergency plan, the HHA is

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/08/2024	
	PROVIDER OR SUPPLIE	R ALTH CARE CENTER		6440 W	ADDRESS, CITY, STATE, ZIP COD 7 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	exempt from eng	aging in its next required					
	full-scale commu	nity-based or individual,					
	facility based fund	ctional exercise following the					
	onset of the eme	rgency event.					
	(ii) Conduct an ad	dditional exercise every 2					
	1 .	ne year the full-scale or					
		se under paragraph (d)(2)(i)					
	of this section is						
		t limited to the following:					
	` '	d full-scale exercise that is					
	community-based						
	facility-based functional exercise; or (B) A mock disaster drill; or						
	1 ' '	p exercise or workshop that					
	1	tor and includes a group					
	discussion, using						
	1	emergency scenario, and a					
		atements, directed					
	to challenge an e	epared questions designed					
		HHA's response to and					
	1 ' '	entation of all drills, tabletop					
		nergency events, and revise					
	· ·	ency plan, as needed.					
	l lic III A 3 cilicig	ency plan, as needed.					
	*[For OPOs at §4	86.360]					
	(d)(2) Testing. Th	ne OPO must conduct					
	exercises to test	the emergency plan. The					
	OPO must do the	e following:					
	(i) Conduct a pap	er-based, tabletop exercise					
	or workshop at le	ast annually. A tabletop					
	exercise is led by	a facilitator and includes a					
	group discussion	, using a narrated, clinically					
		ncy scenario, and a set of					
	1 '	nts, directed messages, or					
		ns designed to challenge an					
		If the OPO experiences an					
		man-made emergency that					
	requires activatio	n of the emergency plan, the					
	OPO is exempt fr	rom engaging in its next					

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	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/08/2024		
	PROVIDER OR SUPPLIE	R ALTH CARE CENTER		6440 V	ADDRESS, CITY, STATE, ZIP COD V 34TH ST NAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE.	(X5) COMPLETION DATE
	of the emergency (ii) Analyze the C maintain docume exercises, and end the [RNHCl's and needed. *[RNCHIs at §40 (d)(2) Testing. The exercises to test RNHCl must do to (i) Conduct a papa at least annually, group discussion narrated, clinically scenario, and a se directed message designed to chall (ii) Analyze the Remaintain docume exercises, and end the RNHCl's eme Based on record re failed to conduct of plan at least twice unannounced staff	PPO's response to and entation of all tabletop mergency events, and revise d OPO's] emergency plan, as 03.748]: ne RNHCI must conduct the emergency plan. The	E 00	039	It is the intention of Northwe Healthcare Center to conduct exercises to test the emergency plan at least twict per year. 1 1. What corrective	et .	06/07/2024
		n annual full-scale exercise that			action(s) will be accomplished to those residents found to	ed	

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a. When a community-based exercise is not

b. If the LTC facility experiences an actual natural

of the emergency plan, the LTC facility is exempt

full-scale functional exercise for 1 year following

or man-made emergency that requires activation

accessible, conduct an annual individual,

from engaging its next required full-scale

community-based or individual, facility-based

facility-based functional exercise.

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deficiency.

have been affected by the

preparedness exercise will be

exercises in twelve months. No

residents were affected by the

compliance of two facility

completed by 6/7/2024 to maintain

deficient practice:

A second emergency

If continuation sheet

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CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED
		155041	B. WING		05/08/2024
	ROVIDER OR SUPPLIER	L LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD V 34TH ST VAPOLIS, IN 46224	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	the onset of the actu (ii) Conduct an addi include, but is not li a. A second full-sca community-based o functional exercise. b. A mock disaster o c. A tabletop exerci facilitator that inclu a narrated, clinically and a set of problem messages, or prepar challenge an emerge (iii) Analyze the LT maintain documenta exercises, and emer LTC facility's emer accordance with 42 deficient practice co Findings include: Based on review of documentation date Administrator and t during record review 05/08/24, document emergency preparec within the most record not available for review facility activated the	tal event. itional exercise that may imited to the following: all exercise that is in an individual, facility-based drill; or see or workshop that is led by a des a group discussion, using sy-relevant emergency scenario, in statements, directed and drills; response to and action of all drills, tabletop gency events, and revise the gency plan, as needed in CFR 483.73(d)(2). This build affect all occupants. "Disaster Plan" d 10/31/23 with the he Maintenance Director from 9:50 a.m. to 1:10 p.m. on tation regarding a second dness exercise conducted ent twelve month period was givew. Based on interview at the few, the Administrator stated the eir Covid-19 response due to		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 taken: A second emergency preparedness exercise will be completed by 6/7/2024 to main compliance of two facility exercises in twelve months. Not residents were affected by the deficiency. 3 3. What measures will be put in place or what systems 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 Februal Both exercises have been add to the preventative maintenant binder. 4 4. How the corrective	nt d be ntain o e e titic ure A
		2/23 and documented the		action(s) will be monitored to	
	_	documentation regarding a		ensure the deficient practice	
	second exercise was	s not available for review.		will not recur, i.e., what quali assurance program will be p	-
	These findings were	e reviewed with the		in place:	
		he Maintenance Director		The Administrator will plan and	d
	during the exit conf			direct emergency plan testing according to regulation. Two	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/08/2024
	ROVIDER OR SUPPLIER VEST MANOR HEA	LTH CARE CENTER	6440 V	ADDRESS, CITY, STATE, ZIP COD V 34TH ST NAPOLIS, IN 46224	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w Department of Heal 483.90(a). Survey Date: 05/08 Facility Number: 0 Provider Number: 1002 At this Life Safety C Manor Health Care compliance with Re Medicare/Medicaid Life Safety from Fit National Fire Protec Life Safety Code (L	00015 155041	K 0000	exercises will be scheduled an completed unless an actual natural or man-made emergency plan. Exercises with documented, and results will be presented to QAPI committee upon completion to determine changes in the facility emergency plan. Emergency plan testing been added to the QAPI agencensure compliance. 5 5. By what date the systemic changes will be completed: 6/7/2024 Preparation and or execution this plan of correction does not constitute admission or agree by the provider of the truth of facts alleged or conclusions so forth in the statement of deficiencies. The plan of correction is prepared and/or executed because it is require the provisions of federal and so law	of of ment the et

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 05/08/2024	
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 \	ADDRESS, CITY, STATE, ZIP COD W 34TH ST NAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
K 0200 SS=E Bldg. 01	Type III (200) consisprinklered. The fact with smoke detection areas open to the cooperated smoke deterooms. The facility census of 96 at the transport of the cooperated smoke deterooms. The facility census of 96 at the transport	dents have customary access the facility has one detached aundry services which was an appleted on 05/10/24 Requirements - Other Requirements - Other Requirements - Other Requirements - Other Response of Egress are not addressed by the put are deficient. This with the applicable Life FPA standard citation, don Form CMS-2567. In and interview, the facility Fover 60 corridor doors in the fall obstructions or instant use in the case of fire in accordance with LSC cient practice could affect over	K 0200	It is the intention of Northwood Healthcare Center to ensure corridor doors are free from obstructions or impediment full instant use in case of finother emergency. 1 1. What corrective action(s) will be accomplish to those residents found to have been affected by the deficient practice: Positive latching devices were	e all n ts to re or	

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NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224	(X5) COMPLETION	•
, , , , , , , , , , , , , , , , , , ,		
DEFINITION OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG Corridor door set to the Administrator's Office, the Wing I Dining Room, the Wing I 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 intent the door from 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) SIMMARY STATEMENT OF DEFICENCE PROFEDIATE PROFEDIATE PROFEDIATE TO THE PROFEDIAT	d DATE	

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/08/2024	
	PROVIDER OR SUPPLIER	LTH CARE CENTER	644	EET ADDRESS, CITY, STATE, ZIP COD 0 W 34TH ST DIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPRO	CION (X5) D BE COMPLETION OPRIATE DATE	
				achieved. Substantial comwill be achieved upon six consecutive months of 100 compliance. 5 5. By what date the systemic changes will be completed: 5/27/2024	0%	
K 0211 SS=E Bldg. 01	in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 2 of continuously maintained or impediments to fire or other emergency hangings or draperidors or located so any exit, unless other This deficient practices are sidents, staff and the outside of the faction of the	regeneral ays, corridors, exit cations, and accesses are a Chapter 7, and the means uously maintained free of full use in case of a modified by 18/19.2.2 1. 1.10.1	K 0211	It is the intention of North Healthcare Center to ens means of egress are free obstructions or impedim 1 What corrective act will be accomplished to the residents found to have the affected by the deficient practice: The shear curtain was remarked from the window of the two doors identified during the There were no residents at by the deficiency. 2 How other resident having the potential to be affected by the same definitions.	sure all from ents. cion(s) those been noved o exit e survey. affected	

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	OF CORRECTION	IDENTIFICATION NUMBER 155041	A. BUILDING B. WING	01	COMPLI 05/08/2	ETED
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE
	the aforementioned continually maintain impediments to full or other emergency hung on the exit doc These findings were	e reviewed with the he Maintenance Director		that corrective action(s) taken: The shear curtain was rem from the window of the two doors identified during the There were no residents a by the deficiency. 3 What measures will put in place or what syste changes will be made to ensure that the deficient practice does not recur: The Maintenance Director/Designee will veri doors do not have obstructimpediments weekly. The task was added to the premaintenance log. 4 How the corrective action(s) will be monitore ensure the deficient practice will not recur, i.e., what quassurance program will be in place: The Administrator will veri preventative maintenance with the Maintenance with the Maintenance Director/Designee monthly months. The preventative maintenance log will be proto the QAPI committee until substantial compliance is achieved. Substantial compliance wi achieved upon six consecumonths of 100% complian	be ematic fy exit tions or weekly ventative ed to tice quality be put fy task / for six resented bothly Its will I be utive	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		155041	B. W	ING		05/08/	
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	(X5) COMPLETION DATE
K 0232 SS=E Bldg. 01	unobstructed) seriat least 4 feet and convenient remove on stretchers, exception 19.2.3.4, exception 19.2.3.4, 19.2.3.5 Based on record revinterview; the faciliar requirement for 2 of exception per 19.2.2 states projections in permitted for wheel of the following confusion (a) The wheeled equipment end in the same training program and wheeled equipment emergency. (c) The wheeled equipment emergency. (c) The wheeled equipment in use ii. Medical emerger iii. Patient lift and the This deficient practice.	Ramp Width s or corridors (clear or ving as exit access shall be maintained to provide the all of nonambulatory patients ept as modified by ns 1-5. view, observation and ty failed to meet the clear width f 7 corridors or met an 3.4(4). LSC Section 19.2.3.4(4) to the required width shall be ed equipment, provided that all nditions are met: uipment does not reduce the corridor width to less than 60 occupancy fire safety plan and dress the relocation of during a fire or similar uipment is limited to the and carts in use acy equipment not in use	K 0	232	It is the intention of Northwell Healthcare Center to meet the clear width requirement in the hallway. 1 What corrective actions will be accomplished to those residents found to have been affected by the deficient practice: The stored items were remove from the hallway. The facility is ordered different medication at 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 deficie practice will be identified and that corrective action(s) will taken: The stored items were removed.	est ne ne (s) se n ed has and	07/06/2024

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155041	B. Wl	ING		05/08	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	L		6440 W	/ 34TH ST		
NORTHV	VEST MANOR HEA	LTH CARE CENTER		INDIAN	IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	T		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
					from the hallway. The facility h	nas	
	Based on review of	the "Fire Policy and			ordered different medication a	and	
	Procedure" section	of the "Disaster Plan" dated			treatment carts to meet		
	10/31/23 with the A	dministrator and the			compliance. There were no		
	Maintenance Direct	or during record review from			residents affected by the		
	_	m. on 05/08/24, the health care			deficiency.		
		ty plan addressed the					
	relocation of wheeled equipment during a fire or similar emergency. Page 22 of the aforementioned				3 What measures will be		
					put in place or what systema	atic	
	documentation stated, "All wheeled equipment				changes will be made to		
		m the halls and placed in the			ensure that the deficient		
		preventing a safe resident			practice does not recur:		
		on observations with the			The Maintenance		
		or during a tour of the facility			Director/designee will monitor		
	_	:20 p.m. on 05/08/24, a wheeled			corridors for obstructions wee	•	
		d in the corridor outside Room			The weekly task was added to		
		vas stored in the corridor			preventative maintenance log		
		A Hoyer lift was stored in the			education was provided for the	е	
		om 121. The corridor outside			proper storage of items.		
		g rooms measured 84 inches in					
		with a measuring tape. The			4 How the corrective		
		led equipment in the corridor			action(s) will be monitored to		
		in the path of egress to,			ensure the deficient practice		
		hes, 59 inches and 59 inches.			will not recur, i.e., what qual	-	
		erre the wheeled equipment was			assurance program will be p	ut	
		d on interview at the time of			in place: The Administrator will verify		
		e Maintenance Director			preventative maintenance tas	l _r	
	· · · · · · · · · · · · · · · · · · ·	ntioned wheeled equipment			with the Maintenance	IX.	
	_	nobstructed corridor width of			Director/Designee monthly for	· eiy	
	the corridor to less				months. The preventative	SIA	
	ine confidente less	oo mones.			maintenance log will be prese	nted	
	These findings were	e reviewed with the			to the QAPI committee month		
	_	he Maintenance Director			for six months. Audit results v	-	
	during the exit conf				be reported to the QAPI	••••	
	and the one oom				committee until substantial		
	3.1-19(b)				compliance is achieved		
	- (-)				2 2		
					5 By what date the syste	mic	

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changes will be completed:

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	X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/08/2024	
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440 V	ADDRESS, CITY, STATE, ZIP COD V 34TH ST NAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
K 0321 SS=E Bldg. 01	barrier having 1-hi (with 3/4 hour fire automatic fire extinaccordance with 8 approved automation option is used, the from other spaces partitions and doo Doors shall be sel automatic-closing nonrated or field-ado not exceed 48 the door. Describe the floor hazardous areas to REMARKS. 19.3.2.1, 19.3.5.9 Area Separation a. Boiler and Fuel-b. Laundries (large c. Repair, Maintend. Soiled Linen Rogallons) e. Trash Collection (exceeding 64 galf. Combustible Stotover 50 square feg. Laboratories (if	are protected by a fire our fire resistance rating rated doors) or an inguishing system in 1.7.1 or 19.3.5.9. When the cic fire extinguishing system is areas shall be separated by smoke resisting rs in accordance with 8.4. If-closing or and permitted to have applied protective plates that inches from the bottom of and zone locations of that are deficient in Automatic Sprinkler N/A Fired Heater Rooms or than 100 square feet) sance, and Paint Shops from soms (exceeding 64 on Rooms lons) orage Rooms/Spaces set) classified as Severe		7/6/2024		
	failed to ensure 4 of	2) on and interview, the facility Fover 11 hazardous areas such age rooms/spaces (over 50	K 0321	It is the intention of Northwe Healthcare Center to ensure that hazardous are separate	03/2//2021	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	01	COMPLETED
		155041	B. W	ING		05/08/2024
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	R			/ 34TH ST	
NORTHV	WEST MANOR HEA	ALTH CARE CENTER			IAPOLIS, IN 46224	
	1					
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	square feet), soiled linen/ trash collection rooms				from other spaces with	
		ons) and boiler and fuel fired			self-closing or automatic	
		separated from other spaces by			closing doors.	, ,
	_	titions and doors. Doors shall			1 What corrective action(
	_	utomatic closing in accordance			will be accomplished to thos	
		deficient practice could affect			residents found to have been	n
	over 20 residents, s	tall and visitors.			affected by the deficient	
	Eindings in abida				practice:	
	Findings include:				The maintenance department	
Based on observations with the Maintenance				corrected the self-closing and		
	Director during a tour of the facility from 1:10 p.m.				latching failure on all doors identified. No residents were	
	to 3:20 p.m. on 05/08/24, the following was noted:				affected by the identified	
	a. the corridor door to the Dialysis Storage Room				deficiency.	
	by Room 167 was equipped with a self-closing				deliciency.	
	1 -	ng mechanism to latch the door			2 How other resident	
		but the door failed to fully			having the potential to be	
		into the door frame when			affected by the same deficie	nt
		iple times. The Dialysis			practice will be identified and	
		greater than 50 square feet in			that corrective action(s) will	
	_	o store combustible boxes and			taken:	
	supplies.				The maintenance department	
		set to the storage room by			corrected the self-closing and	
		ipped with self-closing devices			latching failure on all doors	
	_	nisms to latch the doors into			identified. No residents were	
	the door frame, but	the door set failed to fully			affected by the identified	
		into the door frame when			deficiency.	
	tested to close mult	iple times. The storage room				
	was greater than 50	square feet in size and was			3 What measures will be	
	used to store combi	ustible boxes and supplies.			put in place or what systema	atic
	c. the corridor door	to the Electrical Room by the			changes will be made to	
	Geriatrician's Offic	e was equipped with a			ensure that the deficient	
	self-closing device	and a latching mechanism to			practice does not recur:	
		the door frame but the door			The Maintenance	
		close and latch into the door			Director/Designee will check t	he
		to close multiple times. The			doors identified weekly for one	Э
	Electrical Room co	ntained one natural gas fired			month. After four weeks of	
	furnace.				compliance is obtained, month	ıly
		to the Employees Only room			checks will resume as schedu	led.
	by the Wing 1 nurs	e's station was equipped with				

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED	
		155041	B. Wl	B. WING			/2024
	SUMMARY (EACH DEFICIEN REGULATORY OF a self-closing device latch the door into the	ALTH CARE CENTER STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION e and a latching mechanism to the door frame but the door close and latch into the door		6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST APOLIS, IN 46224 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) 4 How the corrective action(s) will be monitored to ensure the deficient practice	TE D	(X5) COMPLETION DATE
	frame when tested to Employees Only ro soiled linen cart and cart. Based on interview observations, the Mathematical from other partitions and doors. These findings were	to close multiple times. The om contained one 96 gallon d one 64 gallon soiled linen at the time of the laintenance Director agreed four hazardous areas were not er spaces by smoke resistant s.			will not recur, i.e., what qualiassurance program will be pin place: The Maintenance Director/designee will check the self-closing or automatic closing devices on the identified doors weekly for one month. All door checked are expected to have 100% closure rate for 4 weeks Weekly monitoring results will presented to QAPI committee review. Monthly monitoring will resume once establishing 4 words 100% closure rate. 5 By what date the system changes will be completed: 5/27/2024	ne ng s rs a s be for I eeeks	
K 0324 SS=D Bldg. 01	Ventilation Control Commercial Cook residential cooki appliances such a toasters) are used cooking in accord 19.3.2.5.2 cooking facilities smoke compartments						

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18.3.2.5.3, 19.3.2.5.3, or

* cooking facilities in smoke compartments

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, , ,		ľ í			ì í	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPLETED 05/08/2024	
		155041	B. Wl	inG		05/08/	/2024
	PROVIDER OR SUPPLIER	LTH CARE CENTER		6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	conditions under 1 Cooking facilities NFPA 96 per 9.2.3 enclosed as hazal be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on observation	n 18.3.2.5.4, 19.3.2.5.1	K 0	324	It is the intention of Northwe Healthcare Center to ensure		05/27/2024
	filters were installed Edition, Standard for Protection of Comm Section 6.1.1 states baffles, or other list use with commercial provided. Section 6 not be used unless 6 a listed exhaust hoo a primary filter in a	d correctly. NFPA 96, 2011 or Ventilation Control and Fire mercial Cooking Operations, listed grease filters, listed ed grease removal devices for al cooking equipment shall be 5.1.3 states mesh filters shall evaluated as an integral part of d or listed in conjunction with ecordance with UL 1046. This buld affect over three staff and			kitchen filters are installed correctly. 1 What corrective action will be accomplished to thos residents found to have been affected by the deficient practice: The correct kitchen exhaust filter were installed. There were no residents, staff or visitors affected.	(s) se n	
	Director during a to to 3:20 p.m. on 05/6 system grease filter exhaust system wer angle not less than 4. The kitchen range h with a drip tray. W would not drain to t documentation was hood exhaust system indicating the system accordance with UI the time of the obse	ons with the Maintenance our of the facility from 1:10 p.m. 08/24, all kitchen exhaust in the kitchen range hood in mesh filters installed at an 45 degrees from the horizontal. The sood system was equipped ith mesh filters in place, grease the installed drip tray. No noted on the kitchen range in or was available for review in was evaluated in 1046. Based on interview at the revisions, the Maintenance skitchen exhaust system grease			2 How other resident having the potential to be affected by the same deficie practice will be identified and that corrective action(s) will taken: The correct kitchen exhaust fi were installed. There were no residents, staff or visitors affects. 3 What measures will be put in place or what systems 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	d be Iters cted.	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155041	B. W	ING		05/08/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			/ 34TH ST		
NORTHV	VEST MANOR HEA	ALTH CARE CENTER			APOLIS, IN 46224		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	filters in the kitcher	n range hood exhaust system			maintenance book. The		
	have always been n	nesh filters but agreed the			maintenance Director and Die	lary	
	installed kitchen rai	nge hood filters were not			Manager were educated on th	е	
	baffles.				proper filters required. The		
					Maintenance Director will be		
	These findings were				responsible for ordering kitche	n	
	Administrator and t	the Maintenance Director			exhaust filter replacements. Ti	ne	
	during the exit conf	ference.			Maintenance Director/Designe	:e	
					will conduct monthly monitorin	g for	
	3.1-19(b)				3 months and then quarterly	ļ	
					ongoing to ensure proper filter	s	
					and proper placement of exha	ust	
					filters		
					4 How the corrective		
					action(s) will be monitored to		
					ensure the deficient practice		
					will not recur, i.e., what quali	-	
					assurance program will be p	ut	
					in place:		
					The Maintenance		
					Director/Designee will monitor		
					kitchen exhaust filters every		
					month for 3 months for proper		
					and proper placement. Expect		
					compliance is 100%, complian		
					less than 100% will be reporte	d to	
					the QAPI committee. After 3		
					months of 100% compliance,		
					monitoring will be completed		
					monthly as a preventative maintenance task.		
					maintenance task.		
					5 By what date the syster	nic	
					changes will be completed:	IIIC	
					5/27/2024		
					0,21,2027	ļ	
K 0345	NFPA 101						1
SS=F	Fire Alarm Systen	n - Testing and				ļ	
Bldg. 01	Maintenance	J					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPLETED 05/08/2024	
		155041	B. Wl	ing		05/08/	12024
NAME OF I	PROVIDER OR SUPPLIER	?			ADDRESS, CITY, STATE, ZIP COD / 34TH ST		
NORTHV	VEST MANOR HEA	ALTH CARE CENTER			IAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	Fire Alarm Systen Maintenance	n - Testing and					
		m is tested and maintained					
	1	h an approved program					
		e requirements of NFPA 70,					
		Code, and NFPA 72,					
		m and Signaling Code.					
		n acceptance, maintenance					
	and testing are re						
		IFPA 70, NFPA 72					
		view and interview, the facility	K 0	345	It is the intention of Northwe	st	05/27/2024
		of 1 fire alarm systems in			Healthcare Center to ensure		
		FPA 72, National Fire Alarm			the facility fire alarm system	is	
		y LSC Sections 19.3.4.5.1 and			maintained		
		tion 14.3.1 states that unless			1 What corrective action		
	_	1 by 14.3.2, visual inspections			will be accomplished to thos		
	_	in accordance with the			residents found to have bee	n	
		14.3.1, or more often if required ving jurisdiction. Table 14.3.1			affected by the deficient		
	1 -	wing must be visually			practice: A visual semi-annual inspection	an.	
	inspected semi-anni	•			will be performed. No residen		
	a. Control unit troul	-			were affected.		
	b. Remote annuncia	•			word undeted.		
		s (e.g. duct detectors, manual			2 How other resident		
		eat detectors, smoke detectors,			having the potential to be		
	etc.)				affected by the same deficie	nt	
	d. Notification appl	iances			practice will be identified an		
	e. Magnetic hold-op				that corrective action(s) will	be	
		ice could affect all residents,			taken:		
	staff and visitors.				A visual semi-annual inspection		
					will be performed. No residen	ts	
	Findings include:				were affected.		
	Based review of the	e fire alarm system inspection			3 What measures will be		
		larm System Inspection"			put in place or what systema	atic	
		ed 04/14/23 and 04/18/24 with			changes will be made to		
		nd the Maintenance Director			ensure that the deficient		
		w from 9:50 a.m. to 1:10 p.m. on			practice does not recur:		
		mi-annual fire alarm system			The semi-annual visual inspe		
	I inspection documer	ntation six months after			was completed in May and ad	lded	1

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 05/08/2024		
	PROVIDER OR SUPPLIER	LTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST INDIANAPOLIS, IN 46224				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CCTION (X5) ULD BE PROPRIATE COMPLETION DATE		
	interview at the tim Administrator and t agreed visual semi- documentation for t	railable for review. Based on e of record review, the the Maintenance Director annual inspection the facility's fire alarm system 14/23 was not available for		to the preventative main schedule six months after annual inspection conductive contracted facility in Visual inspection is schedule.	er the acted by April. eduled for		
	These findings were Administrator and t during the exit conf 3.1-19(b)	he Maintenance Director		4 How the corrective action(s) will be monitorensure the deficient provided in place: The Maintenance Direct designee will meet with a Administrator monthly to scheduled inspections a completed monthly for some The results will be report QAPI committee. Expect inspection completion completed monthly for some the second completed monthly for some the second completion com	ored to actice a quality I be put or or the overify re ix months. ted to the ted ompliance		
K 0351 SS=E Bldg. 01	by construction tyl throughout by an a sprinkler system in 13, Standard for th Systems. In Type I and II co protection measur	Installation nd hospitals where required					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155041	A. BUII B. WIN		01	COMPL 05/08/	
		100041	B. WIN			03/00/	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
NORTHV	VEST MANOR HEA	ALTH CARE CENTER			′ 34TH ST APOLIS, IN 46224		
	1				A OLIO, IIV 40224		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		REFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DLI ICILACTI		DATE
	sprinklers.	or local regulations prohibit					
	•	klers are not required in					
		patient sleeping rooms					
		the closet does not exceed					
		sprinkler coverage covers					
	•	t as required by NFPA 13,					
		Illation 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, 1	19.3.5.10, 9.7, 9.7.1.1(1)					
		on and interview, the facility	K 035	51	It is the intention of Northwe	st	05/27/2024
		el armover sprinkler pipes in 1			Healthcare Center to ensure		
	_	tments were installed in			the sprinkler components are		
		e requirements of NFPA 13,			installed and secured proper	ly.	
		stallation of Sprinkler Systems.					
		tion, at Section 9.2.3.5.1 states			1 What corrective action(•	
	the cumulative hori				will be accomplished to thos		
		er to a sprinkler, sprinkler			residents found to have beer	1	
		hall not exceed 24 inches for thes for copper tube. This			affected by the deficient		
		ould affect over 10 residents,			practice: The identified sprinkler bracke		
	_	the vicinity of the Mechanical			was secured to the ceiling. No		
		ne facility's water softeners.			residents were affected by the		
	Troom containing to	ie raemity s water sorteners.			identified deficiency.		
	Findings include:				identined denoteries.		
					2 How other resident		
	Based on observation	ons with the Maintenance			having the potential to be		
	Director during a to	our of the facility from 1:10 p.m.			affected by the same deficier	nt	
	to 3:20 p.m. on 05/0	08/24, a 41 inch armover length			practice will be identified and	d	
		ted steel sprinkler piping was			that corrective action(s) will	be	
		Mechanical Room above the			taken:		
	· ·	prinkler bracket was detached			The identified sprinkler bracke		
	_	d was dangling from the			was secured to the ceiling. No		
		ne length of the unsupported			residents were affected by the		
		ared with a measuring tape.			identified deficiency.		
	Based on interview						
		Iaintenance Director agreed			3 What measures will be		
	the sprinkler bracke	et for the armover length had			put in place or what systema	tic	

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become detached from the ceiling which caused

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changes will be made to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ				RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLET	
		155041	B. W	ING		05/08/20	J24
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
NORTHW	VEST MANOR HEA	LTH CARE CENTER			34TH ST APOLIS, IN 46224		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
	the armover to be un	nsupported.			ensure that the deficient practice does not recur:		
	These findings were	e reviewed with the		Sprinkler installation and brackets			
	Administrator and the Maintenance Director				were added to the visual	NOIO	
	during the exit conf				semi-annual fire inspection.		
	3.1-19(b)				4 How the corrective		
					action(s) will be monitored to	I	
					ensure the deficient practice will not recur, i.e., what quali	I	
					assurance program will be p	- 1	
					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 system	mic	
					changes will be completed: 5/27/2024		
					0/21/2024		
K 0353	NFPA 101						
SS=F		Maintenance and Testing					
Bldg. 01		Maintenance and Testing					
		er and standpipe systems					
		ted, and maintained in IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems.					
		n design, maintenance,					
	-	ting are maintained in a					
		d readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/08/2024 155041 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0353 It is the intention of Northwest 10/01/2024 interview; the facility failed to ensure a full **Healthcare Center to ensure** hydrostatic flush was performed on 1 of 1 the sprinkler system is automatic sprinkler piping systems that were maintained and inspected as internally inspected as required by NFPA 25, 2011 required by NFPA. edition, the Standard for the Inspection, Testing What corrective action(s) and Maintenance of Water-Based Fire Protection will be accomplished to those Systems in Chapter 14, Obstruction Prevention. residents found to have been Section 14.3.2 requires systems shall be examined affected by the deficient for internal obstructions where conditions exist practice: that could cause obstructed piping. Section A hydrostatic flush is scheduled to 14.3.3, states if an obstruction investigation begin on 8/5/2024. The sprinkler indicates the presence of sufficient material to system riser's accelerator was obstruct pipe or sprinklers, a complete flushing inspected and will be replaced on program shall be conducted by qualified 6/10/2024. The data cables were personnel. Section 14.3.1 states if the condition relocated to prevent resting on the has not been corrected or the condition is one sprinkler piping. The Maintenance that could result in obstruction of piping despite Director/Designee will conduct any previous flushing procedures that have been weekly visual inspection to ensure performed, the system shall be examined internally sprinkler system pressures are for obstructions every 5 years. This deficient within adequate levels and practice could affect all residents, staff and sprinkler system monitoring visitors. system is functioning. Findings include: How other resident having the potential to be Based on review of the sprinkler system affected by the same deficient inspection contractor's "Sprinkler: Report of practice will be identified and Inspection" documentation dated 04/12/24 with that corrective action(s) will be the Administrator and the Maintenance Director during record review from 9:50 a.m. to 1:10 p.m. on A hydrostatic flush is scheduled to 05/08/24, the most recent internal pipe inspection begin on 8/5/2024. The sprinkler

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was performed on 07/23/20. Review of the

sprinkler system inspection contractor's

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system riser's accelerator was

inspected and will be replaced on

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE (A. BUILDING B. WING	01		E SURVEY LETED 3/2024
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440	r address, city, state, zip o W 34TH ST NAPOLIS, IN 46224	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION ar Internal Pipe Inspection"	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) 6/10/2024. The data c	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	documentation date inch Tyco Model D Review of the sprin "Invoice #: I67442" stated "Further Wor flush 1 dry system. Based on interview the Administrator state quote from the cont flushing of the facil system had not beer	ar Internal Pipe Inspection" d 07/23/20" indicated the "6 PV-1 System needs flushed." kler system contractor's documentation dated 07/23/20 k Required: Send quote to System was flushed in 2015". at the time of record review, tated he could not find the ractor dated 07/23/20 and ity's automatic sprinkler in performed on or after y due to the Covid-19		6/10/2024. The data of relocated to prevent resprinkler piping. The Market Director/Designee will weekly visual inspective sprinkler system press within adequate levels sprinkler system monit system is functioning. 3 What measures put in place or what sechanges will be made	esting on the Maintenance conduct on to ensure sures are and toring will be systematic	
	pandemic. The Adi Maintenance Direct is operable and wou The Administrator p documentation date system contractor to sprinkler system hy Administrator also sprinkler system co- stated the contractor	ministrator and the for stated the sprinkler system ald function properly if needed. provided "Quote #: Q36684" d 04/12/24 from the sprinkler o "perform a complete dry pipe		ensure that the defici practice does not red The hydrostatic flush on on the facility's inspect schedule. The contract company has placed to inspection in their auto scheduling program. F monitoring was added monthly inspection tas	ient cur: was updated ction cted che cmatic Riser gauge	
	branch lines of the continuous internal debris (rust internal pipe inspect with the Maintenant facility from 1:10 p facility had one dry in the closet in the k These findings were			4 How the correct action(s) will be mon ensure the deficient pwill not recur, i.e., whassurance program win place: The Maintenance Direct designee will meet with Administrator/designee verify scheduled inspense.	itored to practice nat quality will be put ector or th the e monthly to ections are	
	during the exit conf 3.1-19(b)	erence.		completed. The result reported to the QAPI of Expected inspection of compliance will be 100	committee. completion 0%.	
	2. Based on observa	ation and interview, the facility		5 By what date th	e systemic	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155041	 JILDING	onstruction 01	(X3) DATE COMPL 05/08/	ETED
	PROVIDER OR SUPPLIEF	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD 34TH ST APOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	/IDER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE	
	accordance with NI sprinkler systems sl maintained in accor for the Inspection, To Water-Based Fire P 2011 Edition, Section where or designated or repair deficiencies found during the insequired by this starshall be performed personnel or a qualification, tests, accomponents and she authority having juit deficient practice coand visitors in the first Findings include: Based on observation Director during a toto 3:20 p.m. on 05/0 sprinkler system risk kitchen. The air prosystem riser's acceles that offs for the accoposition indicating interview at the tim Maintenance Direct the facility's dry sproperable.	ons with the Maintenance our of the facility from 1:10 p.m. 08/24, the facility had one dry er located in the closet in the essure gauge for the sprinkler erator read zero and the elerator were in the closed it was not operable. Based on e of the observations, the for agreed the accelerator for rinkler system was not		changes will be completed: 10/01/2024		

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COM	TE SURVEY TPLETED 08/2024	
	PROVIDER OR SUPPLIER	ALTH CARE CENTER	6440 V	ADDRESS, CITY, STATE, ZIP C V 34TH ST NAPOLIS, IN 46224	COD	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 0361	failed to maintain 1 accordance with NF the Inspection, Test Water-Based Fire P edition, Section 5.2 not be subjected to either resting on the This deficient pract residents, staff and Director of Nursing Findings include: Based on observation Director during a toto 3:20 p.m. on 05/0 resting on two sepas sprinkler piping in the attic access in the E Based on interview observations, the M the aforementioned used to support non These findings were Administrator and the during the exit confidence of the support o	ons with the Maintenance our of the facility from 1:10 p.m. 08/24, white data cables were rate sections of horizontal the attic as observed from the Director of Nursing Office. at the time of the faintenance Director agreed sprinkler pipe locations were system components.				
SS=E Bldg. 01	treatment rooms a waiting areas, nur and cooking facilit					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		A. BUILDING <u>01</u> COM			COMP	E SURVEY LETED 3/2024		
		PROVIDER OR SUPPLIEF VEST MANOR HEA	ALTH CARE CENTER		6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224		
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E	(X5) COMPLETION
	TAG	and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation failed to ensure 1 or were separated from capable of resisting required in a sprink Exception per 19.3. That spaces other that treatment rooms, are open to the corridor provided: (a) The space opens onto in are protected by an automatic smoke dowith 19.3.4, and (b) automatic sprinkler to obstruct access to practice could affect visitors in the vicin Room. Findings include: Based on observation Director during a toto 3:20 p.m. on 05/door sets serve as full Therapy Room by I set to the Therapy Fistation was not equiped on either door to late frame. The inactive the Therapy Room was equipped with door. The active legisted on interview in Based on interview.	on and interview, the facility of 1 therapy rooms in Wing 3 on the corridor by a partition the passage of smoke as lered building or met an 6.1(7). LSC 19.3.6.1(7) states an patient sleeping rooms, and hazardous areas shall be reand unlimited in area, pace and corridors which the of the same smoke compartment electrically supervised etection system in accordance of Each space is protected by an of required exits. This deficient et over 20 residents, staff and of the Wing 3 Therapy ons with the Maintenance our of the facility from 1:10 p.m. ons/24, two separate corridor one entrance to the Wing 3 Room 146. The corridor door com nearest Wing 3 nurse's ipped with latching hardware the the doors into the door the leaf in the corridor door set to on the east side of the room a slide bolt on the top of the af in the door set would only the latitude of the	K 0	361	It is the intention of Northw Healthcare Center to ensure doors separating the therapy room is separated by a barrocapable of resisting the passage of smoke. 1 What corrective action will be accomplished to the residents found to have be affected by the deficient practice: Positive latching devices were installed on the therapy door identified. There were no restaffected by the identified deficiency. 2 How other resident having the potential to be affected by the same deficient practice will be identified at that corrective action(s) will taken: Positive latching devices were installed on the therapy door identified. There were no restaffected by the identified deficiency. 3 What measures will be put in place or what system changes will be made to ensure that the deficient practice does not recur: Checking and verifying the full of positive latching devices we added to the monthly prevent maintenance monitoring.	e py rier n(s) pse en re s sidents ent nd II be re s sidents ent c unction vas	05/27/2024

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		(X2) MULTIPLE A. BUILDING B. WING	A. BUILDING <u>01</u> Co		3) DATE SURVEY COMPLETED 05/08/2024	
	PROVIDER OR SUPPLIER	LTH CARE CENTER	6440	T ADDRESS, CITY, STATE, ZIP COE W 34TH ST ANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	Therapy Room, he of was converted to a to corridor door sets to equipped with a post door leaf to latch the These findings were	he Maintenance Director		4 How the corrective action(s) will be monitor ensure the deficient prawill not recur, i.e., what assurance program will in place: The Administrator/Design complete an audit of the preventative maintenance verify door latching syste inspections are complete audit will be completed maix months. Audit results reported to the QAPI confuntil substantial compliant achieved. Substantial compliant achieved. Substantial compliance. 5 By what date the schanges will be completed 5/27/2024	red to ctice quality be put nee will e binder to m d. The nonthly for will be nmittee nce is mpliance	
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containir combustible mater	corridor openings in other osures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material gire for at least 20 fully sprinklered smoke only required to resist the corridor doors and doors in glammable or rials have positive latching atches are prohibited by				

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If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155041	B. W	ING		05/08/	2024
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD		
NODTU	A/FOT MANIOD LIE	ALTIL CADE CENTED			/ 34TH ST		
NORTH	WEST MANOR HEA	ALTH CARE CENTER		INDIAN	IAPOLIS, IN 46224		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
	I -	These requirements do not spaces that do not contain					
	flammable or com						
		en bottom of door and floor					
		ceeding 1 inch. Powered					
	_	with 7.2.1.9 are permissible					
	if provided with a	device capable of keeping					
		hen a force of 5 lbf is					
		no impediment to the					
	I	rs. Hold open devices that					
		door is pushed or pulled are					
	1 '	ed protective plates of re permitted. Dutch doors					
	_	6 are permitted. Door					
	_	beled and made of steel or					
		compliance with 8.3,					
	unless the smoke	compartment is					
	sprinklered. Fixed	fire window assemblies are					
	•	n sprinklered compartments					
		ctions in area or fire					
		s or frames in window					
	assemblies.						
	10 3 6 3 12 CER	Parts 403, 418, 460, 482,					
	483, and 485	1 413 400, 410, 400, 402,					
	1	(S details of doors such as					
		ngs, automatics closing					
	devices, etc.	-					
		on and interview, the facility	K 0	363	It is the intention of Northwe	st	05/27/2024
		f over 60 corridor doors had no			Healthcare Center to ensure		
	_	ing and latching into the door			that corridor doors are not		
		sist the passage of smoke.			impeded from closing and		
	residents, staff and	ice could affect over 20			latching into their door frame	€.	
	residents, start and	v1511015.			1 What corrective action(e)	
	Findings include:				will be accomplished to thos	•	
	8				residents found to have been		
	Based on observation	ons with the Maintenance			affected by the deficient		
	Director during a to	our of the facility from 1:10 p.m.			practice:		
		08/24, the ceiling mounted track			The privacy curtain track was		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: X23N21 Facility ID: 000015

If continuation sheet Page 45 of 51

NAME OF PROVIDER OR SUPPLIER NORTHWEST MANOR HEALTH CARE CENTER NORTHWEST MANOR HEALTH CARE CENTER NORTHWEST MANOR HEALTH CARE CENTER SUMMARY STATEMENT OF DEERCIENCIE (PACH DEFICIENCY MIST IS PRECEDED BY RILL ATO) TAO REQULATORY OR IS DENTIFYING NORMATION TAO TO the privacy curtain for the resident bed neurest the corridor door use 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 path of the swing of the corridor door to rear from and would not ensure the door would close and latch 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) SWENTER ADDRESS, CITY, STATE, ZIP COD 64440 W 34TH ST INDIANAPOLIS, IN 46224 ID PROVIDERS FLATOR CORRECTION (XS) COMPLETION (COMPLETION DATE TAO DEPONDENT FLATOR CORRECTION (XS) (XS) (XS) (XS) (XS) (XS) (XS) (XS)		NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE SURVEY
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PRINTED: 06/06/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		A. BUILDING B. WING	01	COMPLETED 05/08/2024	
	ROVIDER OR SUPPLIER	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST APOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				maintenance department roun results will be presented in QA Door closure and latching aud will be expected to be 100%. 5 By what date the syster changes will be completed: 5/27/2024	.PI. its
K 0914 SS=F Bldg. 01	Testing Electrical Systems Testing Hospital-grade recolocations and when anesthesia is adminitial installation, roughling and defined by docume Receptacles not list these locations are exceeding 12 mon (LIM), if installed, a less than or equal the LIM test switch activates both visual LIM circuits with an annual test is performed than or equal to 12 tested per 6.3.3.3. renovation to the effectors are maint associated repairs containing date, roughling results. 6.3.4 (NFPA 99)	oom or area tested, and	K 0914	It is the intention of Northwe	st 05/31/2024
	Based on record rev interview; the facilit	iew, observation and ty failed to ensure ectrical outlet receptacle	K 0914	It is the intention of Northwee Healthcare Center to ensure documentation of electrical	05/31/2024

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X23N21

Facility ID: 000015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155041 B. WING 05/08/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6440 W 34TH ST NORTHWEST MANOR HEALTH CARE CENTER INDIANAPOLIS, IN 46224 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE testing for all resident sleeping rooms was outlet receptacle testing for all available for review in accordance with NFPA 99. resident rooms. NFPA 99, Health Care Facilities Code, 2012 What corrective action(s) Edition, Section 6.3.4.1.3 states receptacles not will be accomplished to those listed as hospital-grade at patient bed locations residents found to have been and in locations where deep sedation or general affected by the deficient anesthesia shall be tested at intervals not practice: exceeding 12 months. NFPA 99, Health Care The maintenance department Facilities Code, 2012 Edition, Section 6.3.4.1.1 labeled resident room receptacle states hospital-grade receptacles testing shall be outlets. An annual test was performed after initial installation, replacement or completed on each resident room servicing of the device. Section 6.3.3.2, receptacle. Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be How other resident confirmed by visual inspection. The continuity of having the potential to be the grounding circuit in each electrical receptacle affected by the same deficient shall be verified. Correct polarity of the hot and practice will be identified and neutral connections in each electrical receptacle that corrective action(s) will be shall be confirmed; and retention force of the taken: grounding blade of each electrical receptacle The maintenance department (except locking-type receptacles) shall be not less labeled resident room receptacle than 115 grams (4 ounces). Section 6.3.4.2.1.2 outlets. An annual test was states, at a minimum, the record shall contain the completed on each resident room date, the rooms or areas tested, and an indication receptacle. of which items have met, or have failed to meet, the performance requirements of this chapter. What measures will be This could affect all residents. put in place or what systematic changes will be made to Findings include: ensure that the deficient practice does not recur: Based on record review with the Administrator A receptacle testing flowsheet and the Maintenance Director from 9:50 a.m. to was added to the preventative 1:10 p.m. on 05/08/24, electrical receptacle maintenance binder. Fach inspection and testing documentation for all resident room receptacle was resident sleeping rooms within the most recent identified and tested. Each twelve month period was not available for review. resident room receptacle was Based on interview at the time of record review, scheduled for routine annual

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the Maintenance Director agreed electrical

receptacle inspection and testing documentation for all resident sleeping rooms for the most recent

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How the corrective

inspection.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155041		A. BUILDING B. WING	01	COMPLETED 05/08/2024	
	ROVIDER OR SUPPLIER	LTH CARE CENTER	6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K 0920 SS=E	Based on observation Director during a too to 3:20 p.m. on 05/0 rooms had non-hosp installed in the room These findings were Administrator and too during the exit confect 3.1-19(b) NFPA 101 Electrical Equipment	reviewed with the ne Maintenance Director		action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be properties. The Administrator/designee waudit preventative maintenance binder monthly for six months review receptacle testing completed. The process and results will be reviewed by the QAPI committee. 5 By what date the system changes will be completed: 5/31/2024	ty ut iill e to
Bldg. 01	Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assembl assembled by quathe conditions of 1 the patient care vic non-PCREE (e.g., except in long-term do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity) non-patient care roother UL standard used with general cords are not used	d electrical equipment			

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X23N21

Facility ID: 000015

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u> COMPL			(X3) DATE SURVEY COMPLETED	
		155041	B. WING 05/08/2024			
	PROVIDER OR SUPPLIER	LTH CARE CENTER		6440 W	ADDRESS, CITY, STATE, ZIP COD / 34TH ST IAPOLIS, IN 46224	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	temporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 98 (NFPA 70), 590.3 (NFPA 70), 590.3 (NFPA 70), 590.3 (NFPA 70), 590.3 (NFPA 70), Section electrical wiring and NFPA 70, National NFPA 70, National NFPA 70, Article 4 specifically permitted shall not be used as a structure. LSC Securice equipment of safety shall be design accordance with NFPA 99, Standard edition, defines pation of a health care facinitended to be examination and tree extends vertically to floor. NFPA 99, Securice appliances grounding conducted be permitted provided the patient care vicinity is defined and the securical provided the patient care vicinity is defined and the securical provided the patient care vicinity is defined and the securical provided the patient care vicinity is defined and the securical provided the patient care vicinity is defined and the securical provided the patient care vicinity is defined and the securical provided the patient care vicinity is defined and the securical provided affect over 100	moved immediately upon purpose for which it was its the conditions of 10.2.4. (a), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 (D) and interview, the facility is 3 extension cords including of used as a substitute for 19.5.1 requires utilities to in 9.1. LSC 9.1.2 requires id equipment to comply with Electrical Code, 2011 Edition. 100.8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of action 4.5.7 states any building or safeguard provided for life and, installed and approved all applicable NFPA standards. For Health Care Facilities, 2012 ent care areas as any portion lity wherein patients are nined or treated. Patient care is a space, within a location mination and treatment of a ft (1.8 m) beyond the normal chair, table, treadmill, or other the patient during atment. A patient care vicinity of 7 ft 6 in. (2.3 m) above the action 10.4.2.3 states household not commonly equipped with the sin their power cords shall ed they are not located within nity. This deficient practice of residents, staff and visitors.	K 0		It is the intention of Northwee Healthcare Center to ensure that extension cords and postrips are not used as a substitute for fixed wiring. 1 What corrective actions will be accomplished to those residents found to have bee affected by the deficient practice: The extension cord and powers strip identified were removed. The resident was affected by the identified deficiency. 2 How other resident having the potential to be affected by the same deficie practice will be identified and that corrective action(s) will taken: A facility search did not find a other extension cord or power being used as a substitute for fixed wiring. 3 What measures will be put in place or what systems 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 strip extension cords or power st	est 05/27/2024 wer (s) se n r No nt d be ny r strip

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155041	B. WING		05/08/2024		
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 6440 W 34TH ST			
NORTHWEST MANOR HEALTH CARE CENTER			INDIANAPOLIS, IN 46224				
HORTHWEST WARRON TIEAETH OAKE GENTER				111211111111111111111111111111111111111			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOCK CROSS-REFERENCED TO THE AFT DEFICIENCY)		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	5111		DATE
	Director during a tour of the facility from 1:10 p.m.				being used out of compliance.		
		08/24, a CPAP machine and two			Once four weeks of 100%		
	cell phone charging cables were plugged into a		compliance is achieved,				
	power strip placed on top of a table within one			monitoring will be completed			
	foot of the resident bed nearest the corridor door				ongoing monthly.		
	in resident sleeping Room 138. The UL listing of						
	the power strip was 1363A. Based on interview at				4 How the corrective		
	the time of the observations, the Maintenane			action(s) will be monitored to		0	
	Director agreed a power strip was being used in				ensure the deficient practice		
	the patient care vicinity for PCREE and				will not recur, i.e., what quality		
	non-PCREE and was also being used as a				assurance program will be put		
	substitute for fixed wiring at the aforementioned				in place:		
	location. In addition, an extension cord was				The Maintenance		
	plugged into a power strip placed on the floor for				Director/designee will conduct		
	a laptop computer on top of an employee's desk in				weekly rounds to identify		
	the Therapy Room. The Maintenance Director				extension cords or power strips		
	agreed the extension cord and power strip were				being used out of compliance.		
	being used as a substitute for fixed wiring in the				Weekly rounds will be conducted		
	Therapy Room.			for four weeks. After four weeks of		ks of	
					100% compliance, rounds will be		
	These findings were reviewed with the				conducted monthly ongoing.		
	Administrator and the Maintenance Director				Monthly rounds will be reviewed		
	during the exit conference.				with the Administrator/designee		
					monthly. Results to be reported to		
	3.1-19(b)				the QAPI committee. Expected		
					compliance is 100%.		
					5 By what date the systemic		
					changes will be completed:		
					5/27/2024		