STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155788	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/17/13 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Greenwood Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and hard wired smoke detectors in all resident sleeping rooms. The facility has	K010000	October 1, 2013 Kim Rhoades, DirectorLong Term Care DivisionIndiana State Department of Health2 North Meridian StIndianapolis, IN 46204 Dear Ms Rhoades, On September 17, 2013 a Life Safety Code Survey was conducted at Greenwood Meadows. We respectfully request this document be submitted as the Plan of Correction and be considered for desk review by the staff of your division. If any questions arise regarding this request or attached documents, please feel free to contact me at your earliest convenience. Respectfully submitted, Austin Steele, HFA Cc: Chris Shuey, Director of Operations Sue Hornstein, Director of Compliance Martha Herron, Director of Clinical Services File	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	a capacity of 171 and had a census of 158 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/23/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4 Based on observation, interview and record review; the facility failed to ensure the clear width of 1 of 6 corridors was at least eight feet wide. This deficient practice could affect 24 residents on 300 hall as well as visitors and staff using the service hall exit during an emergency evacuation. Findings include: Based on observation on 09/17/13 at 1:15 p.m. with the Maintenance Supervisor, there was one resident bed and three utility carts against the west corridor wall reducing the exit corridor width to four feet. Based on interview on 09/17/13 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned items were regularly stored in the Service corridor and would not allow an eight foot clear width to exit through. Based on record review on 09/17/13 at 2:45 p.m. with the Maintenance Supervisor, the facility floor plan identified the Service corridor as the secondary evacuation route	K010039	What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice: · The one bed and 3 carts were immediately relocated to the adjacent storage room How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken: · Any resident that resides on the 300 hall have the potential to be impacted by this practice. · Daily checks will be completed by the Maintenance Supervisor/ designee that nothing is noted to be in the service hallway. · Dietary staff/ Housekeeping/ and Maintenance will be in-serviced by Registered Dietician and Housekeeping Supervisor on but not limited to: Corridor width requirements, fire safety, and evacuation procedure and importance. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: · Dietary staff/ Housekeeping/ and Maintenance will be in-serviced by Registered Dietician and Housekeeping Supervisor on but	10/01/2013

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	for the residents on 300 hall and this was not disputed by the Maintenance Supervisor. 3.1-19(b)		not limited to: Corridor width requirements, fire safety, and evacuation procedure and importance. · Signage stating to keep hallway clear will be placed on the hall. · Daily checks will be completed by the Maintenance Supervisor/ designee that nothing is noted to be in the service hallway. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie what quality assurance program will be put into place: · An Environmental Safety CQI Tool will be completed as a monitoring tool. This tool will be completed weekly x4, bi-monthly x2, then on a quarterly basis until continued compliance is maintained for 2 consecutive quarters by the Director of Nursing Services or designee. If a threshold of 95% is not met, the results will be reviewed by the CQI committee and an action plan will be developed. The CQI tool will be overseen by the Director of Nursing, Medical Director, and its members. Date of Completion: 10-1-2012	