

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	<p>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).</p> <p>Survey Date: 12/16/13</p> <p>Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Greenwood Health and Living Community 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated</p>	K010000	<p>This plan of correction is to serve as Greenwood Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Greenwood Health and Living Community or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
---------	--	---------	---	--

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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
	<p>smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 121 and had a census of 99 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/26/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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
K010015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of over 75 rooms. This deficient practice could affect 26 residents, staff or visitors in the vicinity of the Medical Records Office by Room 114.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, three walls of the Medical Records Office by Room 114 had wood paneling installed on the entire wall from floor to ceiling by the file storage cabinets. Based on interview at the time of observation, the Maintenance Director stated none of the walls had been treated with flame retardant material and acknowledged flame spread rating</p>	K010015	<p>K015 Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 1. Wood paneling will be removed from the three walls in the Medical Records office located by room 114. 2. 26 residents and visitors could have had the potential to be affected. 3. When considering wall covering or paneling, the facility will acquire the necessary fire rating documentation before proceeding with installation. This documentation will be maintained in the Maintenance office for inspection. 4. Should there be a remodel or renovation project,</p>	01/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	
	documentation was not available for review for the wood paneling installed at the aforementioned location.  3.1-19(b)		the administrator will review the fire rating documentation and initial the document before work begins. This plan of correction will be submitted to the QA Committee for their review and recommendations. 5. Completion date: January 15, 2014.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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
K010017 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 open use areas were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1 Spaces shall be permitted to be unlimited in area and open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke</p>	K010017	<p>K017 Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 A bid from outside contractor has been received and approved to install automatic</p>	01/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	
	<p>detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect all residents, staff and visitors in the North Dining Room and the South Dining Room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, the North Dining Room, the South Dining Room and the kitchenette in the South Dining Room are each open to the corridor. The North Dining Room is open to the corridor because the latching mechanism on the corridor door set at the entry of the room was "dogged down" preventing the door set from latching into the door frame. The South Dining Room is open to the corridor because the corridor door set at the entry to the room is not equipped with a latching mechanism to latch the door set into the door frame. The South Dining Room kitchenette is open to the South Dining Room because a five foot by four foot serving window in the kitchenette is open to the South Dining Room. Each of the</p>		<p>smoke detection for north dining room, south dining room, and kitchenette area. All residents have the potential to be affected. All automatic smoke detectors will be tested/inspected for sensitivity every other year by an outside contractor to assure in good working order. The inspections will be submitted to the QA Committee for their review and recommendations. Completion date: January 15, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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
	<p>three aforementioned rooms was not provided with an automatic smoke detection system. Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open area was not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. Based on interview at the time of observation, the Maintenance Director acknowledged the North Dining Room, the South Dining Room and kitchenette were open to the corridor without supervision from the nurse's station and were not protected by automatic smoke detection.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013	
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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			
K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 60 residents, staff and visitors in the South Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, a two inch in diameter hole in the ceiling smoke barrier in the mechanical room in the South Dining Room exposed the attic above and did not provide at least a one half hour fire resistance rating. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the ceiling smoke barrier in the mechanical room in</p>	K010025	<p>K025 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 The two inch in diameter hole in the ceiling smoke barrier in the mechanical room off of the south dining room will be repaired to eliminate compromise in the smoke barrier. As well, the four inch hole above the electrical conduits also in the mechanical room off of the south dining room will be repaired to eliminate a compromise in the smoke barrier wall. Sixty residents have the</p>	01/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	
	<p>the South Dining Room did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure openings through 1 of 12 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect 60 residents, staff and visitors in the South Dining Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, a four inch in diameter hole above four electrical conduits was noted in the smoke barrier wall in the mechanical room in the South Dining Room which did not provide at least a one half hour fire resistance rating. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the smoke barrier wall in the mechanical room in the South Dining Room did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p>		<p>potential to be affected. The Administrator and Maintenance Supervisor will inspect all mechanical rooms and storage room to assure that no other smoke barrier walls are compromised. Should a contractor find it necessary to compromise a smoke barrier wall for repairs or upgraded services, the contractor will discuss the need with the Administrator and Maintenance Supervisor. The Maintenance Supervisor and Administrator will make sure the smoke barrier wall is restored. This plan of correction will be submitted to the QA committee for their review and recommendations. Completion date: January 15, 2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013	
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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			
K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would close to form a smoke resistant barrier. Centers for Medicare &amp; Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 58 residents, staff and visitors in the North Dining Room if smoke was allowed to move from one smoke compartment to another.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, the set of corridor smoke barrier doors to the North Dining Room swing in</p>	K010027	<p>K027 Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 A door closing coordinator will be installed on the smoke barrier doors to the north dining room to ensure the door which must close first always closes first. All residents have the potential to be effected. The addition of the door closing coordinator will ensure that this issue will be resolved. The proper function of the fire doors is tested weekly with the weekly generator test. This plan of correction will be submitted to the QA committee</p>	01/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	
	<p>the same direction and are equipped with an astragal but had no door closing coordinator to ensure the door which must close first always closes first. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned set of smoke barrier doors with an astragal had no door closing coordinator to ensure the door equipped with an astragal closes last and forms a smoke resistant barrier.</p> <p>3.1-19(b)</p>		<p>for their review and recommendation. Completion date: January 15, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	
K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure ensure 1 of 13 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 60 residents, staff and visitors in the South Dining Room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, the following openings were noted in the mechanical room in the South Dining Room which contained two natural gas fired water heaters:</p> <p>a. a two inch in diameter hole in the ceiling smoke barrier.</p> <p>b. a four inch in diameter hole above four electrical conduits in the back smoke</p>	K010029	<p>K029 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 The two inch in diameter hole in the ceiling smoke barrier the mechanical room off of the south dining room will be repaired to eliminate compromise in the smoke barrier. A well, the four inch hole above the electrical conduits also in the mechanical room off of the south dining room will be repaired</p>	01/15/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	
	<p>barrier wall.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the ceiling and smoke barrier wall did not not separate the aforementioned mechanical room from other spaces by smoke resistant partitions.</p> <p>3.1-19(b)</p>		<p>to eliminate a compromise in the smoke barrier wall.Sixty residents have the potential to be affected.The Administrator and Maintenance Supervisor will inspect all mechanical rooms and storage rooms to assure that no other smoke barrier walls are compromised.Should a contractor find it necessary to compromise a smoke barrier wall for repairs or upgraded services, the contractor will discuss the need with the Administrator and Maintenance Supervisor.The Maintenance Supervisor and Administrator will make sure the smoke barrier wall is restored.This plan of correction will be submitted to the QA committee for their review and recommendation.Completion date:January 15, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2013	
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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			
K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a</p>	K010038	<p>K038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 The main entrance door equipped with a delayed egress locks will be adjusted to open in 15 seconds when pressure is applied to the door. Fifty eight residents have the potential to be effected. The Maintenance Supervisor or designee will test the door twice per week for thirty days and once per month thereafter as part of the routine maintenance log. Should the door fail to operate, the delayed egress lock will be disabled and a monitor will be assigned at the door until appropriate repairs or adjustment has been accomplished. The successful operation of the door will be tested twice weekly for thirty days and monthly thereafter and a log maintained if the performance of the delayed egress locks. This plan of correction will be submitted to the QA committee for their review and recommendations. Completion date: January 15, 2014.</p>	01/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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	
	<p>delay not exceeding 30 seconds shall be permitted.</p> <p>This deficient practice could affect 58 residents, staff and visitors if needing to exit the facility using the Main Entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, the double door set for the Main Entrance is equipped with a delayed egress lock and provided with signage stating each door could be opened in 15 seconds by pushing on the door with the application of force to the release device but the exit doors failed to open when pushed with the application of force five separate times. Based on interview at the time of observation, the Maintenance Director acknowledged the double door set for the Main Entrance is equipped with delayed egress locks and is provided with signage stating each door could be opened in 15 seconds by pushing on the door with the application of force to the release device but the aforementioned exit doors failed to open when the door set was pushed with the application of force five separate times.</p> <p>3.1-19(b)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  12/16/2013	
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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			
K010069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to ensure 3 of 3 kitchen range hood fire suppression system nozzles were provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:</p> <ul style="list-style-type: none"> <li>a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems</li> <li>b. NFPA 13, Standard for the Installation of Sprinkler Systems</li> <li>c. NFPA 17, Standard for Dry Chemical Extinguishing Systems</li> <li>d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems</li> </ul> <p>NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 2-3.1.4 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign</p>	K010069	<p>K069 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Three of Three kitchen range hood fire suppression system nozzles blow off caps will be replaced.All residents have the potential to be effected.The Maintenance Supervisor will inspect the range hood blowout caps monthly to see that they are still in place.In between inspections the Dietary Supervisor will report missing blowout caps to maintenance.The blow out caps will be replaced.Maintenance will inspect the nozzles monthly to see that the caps remain in place.This plan of correction will be submitted to the QA committee for their review and recommendation.Completion date:January 15, 2014.</p>	01/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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
	<p>materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. This deficient practice could affect three staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, each of three kitchen range hood fire suppression system nozzles was not provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles. Based on interview at the time of observation, the Maintenance Director acknowledged the three kitchen range hood fire suppression system nozzles were not provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the nozzles.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2013	
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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			
K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage locations of greater than 3,000 cubic feet is:</p> <p>a. vented to the outside by a dedicated mechanical ventilation system or by natural venting.</p> <p>b. enclosed with a separation of 1 hour fire resistive construction.</p> <p>If natural venting is used, the vent opening or openings shall be a minimum of 72 square inches in total free area. This deficient practice could affect 6 residents, staff and visitors in the vicinity of the Nutrition Pantry near Room 100.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 3:00 p.m. on 12/16/13, four liquid oxygen containers were stored in the Nutrition Pantry near</p>	K010076	<p>K076 Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. The North Nutrition Pantry will not be used as an oxygen storage room. The four canisters have been removed. This has the potential to affect 6 residents, staff and visitors. The North Nutrition Pantry will not be used as an oxygen storage room. It is possible to add a delivery day so that fewer oxygen tanks are delivered at one time. The unit manager, Administrator and Director of Nursing will monitor the north nutrition to assure that the pantry is not used as an oxygen storage room. This plan of correction will be submitted to the QA committee for their review and recommendations. Completion date: January 15, 2014.</p>	01/15/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155412	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  12/16/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD 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
	<p>Room 100. The Nutrition Pantry did not have a mechanical ventilation system or natural venting. The corridor entry door to the Nutrition Pantry had an affixed label stating the door had 20 minute fire resistance rating. Based on interview at 1:25 p.m., the Director of Nursing stated supplemental oxygen is stored in the Nutrition Pantry and no transfilling occurs in the room. Based on interview at the time of the observations, the Maintenance Director acknowledged the Nutrition Pantry oxygen storage room was not provided with continuous mechanical ventilation or with natural vent openings of greater than 72 square inches in total free area and the corridor entry door fire resistance rating was less than one hour.</p> <p>3.1-19(b)</p>			