

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  09/17/2012
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NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 937 FRY RD GREENWOOD, IN 46142
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K0000	<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: 09/17/12</p> <p>Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620</p> <p>Surveyor: Phillip Komsiski, 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 was fully sprinklered except for the canopy outside Therapy. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and</p>	K0000	<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> <p>We respectfully request a desk review (paper compliance) as a follow up to this survey.</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.

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	<p>battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 86 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/21/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0038 SS=D	<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 exit access was arranged so 1 of 15 exit access doors on 200 hall were not equipped with 2 locking devices on the doors. Section 19.2.2.2.5 requires means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 1 staff member in the room as well as other visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 09/17/12 at 2:22 p.m. with the Maintenance Supervisor, the Bookkeeping office on 200 west hall had a door knob lock and a deadbolt lock on the door leading out the office. Based on interview on 09/17/12 at 2:23 p.m. with the Maintenance Supervisor, it was acknowledged there were two locking devices on the Bookkeeper's office door on 200 west hall.</p> <p>3.1-19(b)</p>	K0038	<p>K 038 I. One of two locking devices has been removed from the Bookkeeping office located on the 200 hall. II. Removal of one of two locks on the bookkeeping office eliminates the potential for residents and staff to be affected by this practice. III. The maintenance director and maintenance staff member have been made aware that two locks on the doors constitute a deficient practice. IV. This plan of correction will be submitted to the Quality Assurance Committee for their oversight/monitoring and recommendations. V. September 17, 2012</p>	10/17/2012			

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K0056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 4 exits with an outside canopy in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior combustible roofs or canopies exceeding four feet in width. This deficient practice could affect 2 residents observed in the east Courtyard adjacent to the Physical Therapy exit as well as visitors or staff.</p> <p>Findings include:</p> <p>Based on observation on 09/17/12 at 1:35 p.m. with the Maintenance Supervisor,</p>	K0056	<p>K56</p> <p>I. The canopy outside the Courtyard exit adjacent to the Physical Therapy room on the center hall has been removed.</p> <p>II. Removing the canopy eliminates the potential for residents and staff to be affected.</p> <p>III. Additions to the physical plant would require approval and inspection by the ISDH assuring that additions to GHLC not protected by the sprinkler system would not occur.</p> <p>IV. This plan of correction will be presented to the Quality Assurance Committee for their recommendations and oversight/monitoring.</p>	10/17/2012			

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	<p>the canopy outside the east Courtyard exit adjacent to the Physical Therapy room on Center hall was attached to the building, extended ten feet from the building, and was constructed of wood with an open ceiling and a corrugated fiberglass roof. Based on interview on 09/17/12 at 1:37 p.m. with the Maintenance Supervisor, it was acknowledged there was no sprinkler head present for the canopy outside the east Courtyard adjacent to the Physical Therapy room exit to provide complete sprinkler coverage for the facility.</p> <p>3.1-19(b)</p>		V. October 3, 2012.	