

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 12/30/2014
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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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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: 12/30/14</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</p>	K010000		
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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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K010046 SS=C	<p>operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 121 and had a census of 88 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 Dennis Austill, Life Safety Code Specialist on 12/31/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document monthly testing of emergency lighting in accordance with LSC 7.9 for 3 of 4 battery powered lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds on every required battery powered emergency lighting system. Equipment shall be fully operational for</p>	K010046	The 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 its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute	01/29/2015

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	<p>the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Light Testing Log for 2013 and 2014" with the Maintenance Director during record review from 9:15 a.m. to 10:40 a.m. on 12/30/14, documentation of monthly functional testing for three of four facility battery powered emergency lights for November 2014 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of monthly functional testing for three of four battery operated lights in the facility for November 2014 was not available for review. Based on observations with the Maintenance Director and Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, a total of four battery powered emergency lights were located in the facility and each light operated when its respective test button was pushed.</p> <p>3.1-19(b)</p>		<p>an agreement or admission of the survey allegations. K 046 NFPA 101 LIFE SAFETY CODE STANDARD I. The corrective actions to be accomplished for those residents found to have been affected by the practice.</p> <p>There was not a particular resident identified to have been affected by the alleged practice.</p> <p>The facility immediately tested the 4 battery powered emergency lights and all lights were operating correctly when tested. The facility has stored the documentation for the test of the battery powered emergency light testing. II. The facility will identify other residents that may potentially be affected by the practice.</p> <p>Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator on keeping written records of visual inspections and tests for the weekly/monthly testing of emergency lighting in accordance with LSC 7.9 for battery powered emergency lights and on manufacture testing recommendation. A post- test will be utilized to ensure the</p>				

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			<p>maintenance staff and housekeeping manager comprehend the requirement of testing and storing written records of visual inspections and tests for emergency lighting in accordance with LSC 7.9 for battery powered emergency lights. The Maintenance Director or designee will test and store written records of visual inspections and tests for weekly/monthly testing of emergency lighting in accordance with LSC 7.9 for battery powered emergency lights and on manufacture testing recommendation. If the testing of the emergency lighting suggest a malfunction the Administrator will be notified immediately and corrections will be made. The Maintenance Director will add the weekly/monthly task to the TELS preventative maintenance program to assure completion of proper testing. IV. The facility will monitor the corrective action by implementing the following measures. The Maintenance Director or designee will notify and provide a copy of the visual inspection or emergency lighting testing to the Administrator when they are completed weekly/monthly. The Administrator or designee will audit the facility's maintenance records for a copy of the battery powered emergency light visual inspections and tests monthly. Any concerns will be addressed.</p>	

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K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 63 of 63 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 	K010048	<p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p> <p>K 048 NFPA 101 LIFE SAFETY CODE STANDARD I. The corrective actions to be accomplished for those residents found to have been affected by the practice. There was not a particular resident identified to have been affected by the alleged practice. The facility's written fire safety plan in the disaster manual has been updated to include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice.</p>	01/29/2015

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	<p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster Manual" documentation with the Maintenance Director during record review from 9:15 a.m. to 10:40 a.m. on 12/30/14, the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>Based on observations with the Maintenance Director and Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, battery operated smoke detectors are installed in each resident sleeping room.</p> <p>Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p>		<p>III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator on the facility's fire safety plan specifically related to staff response in the activation of battery operated smoke detectors installed in resident sleeping rooms. In-service staff on the facility's fire safety plan in the disaster manual specifically related to staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. A post-test will be utilized to ensure staff comprehended the facility's fire safety plan specifically staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. The Maintenance Director or designee will test and store written records of resident sleeping room battery operated smoke detector testing monthly. This task will be added to the TELS preventative maintenance program. IV. The facility will monitor the corrective action by implementing the following measures. The Maintenance Director or designee will conduct a weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the Regional Director of</p>		

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K010053 SS=C	<p>NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7)</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 63 of 63 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be</p>	K010053	<p>Operations to determine the ongoing frequency into the next 90 days to ensure staff are complying and understand staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p> <p>K 053 NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD I.The corrective actions to be accomplished for those residents found to have been affected by the practice There was not a particular resident identified to have been affected by the alleged practice.</p>	01/29/2015	

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	<p>either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Smoke Detector Maintenance Log for 2013/2104" with the Maintenance Supervisor during record review from 9:40 a.m. to 12:45 p.m. on 12/18/14, documentation of resident sleeping room battery operated smoke detector testing for November 2014 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of battery operated smoke detector testing for November 2014 was not available for review. Based on observations with the Maintenance Director and Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, battery operated smoke detectors are installed in all 63 resident sleeping rooms.</p> <p>3.1-19(a)</p>		<p>The facility has completed resident sleeping room battery operated smoke detector testing for December of 2014 and January of 2015 and has stored the documentation of the the testing. II. The facility will identify other residents that may potentially be affected by the practice Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator on conducting tests for resident sleeping room battery operated smoke detectors monthly and to keep written records of the completed tests monthly. A post-test will be utilized to ensure the maintenance staff and housekeeping manager comprehend the requirement of conducting tests and storing documentation of the tests monthly for resident sleeping room battery operated smoke detectors. The Maintenance Director or designee will test and store written records of resident sleeping room battery operated smoke detector testing monthly. This task will be added to the TELS preventative maintenance program. IV. The facility will</p>		

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K010062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on record review, observation and interview; the facility failed to ensure 2 of 2 private fire hydrants was continuously maintained in reliable operating condition and inspected and	K010062	monitor the corrective action by implementing the following measures. The Maintenance Director or designee will notify and provide a copy of the written records of resident sleeping room battery operated smoke detector testing to the Administrator when completed monthly. The Administrator or designee will audit the facility's maintenance records of resident sleeping room battery operated smoke detector testing monthly. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed. K 062 NFPA 101 LIFE SAFETY CODE STANDARD I. The corrective actions to be accomplished for those residents found to have been affected by the practice	01/29/2015	

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	<p>tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:15 a.m. to 10:40 a.m. on 12/30/14, documentation of facility fire hydrant inspection within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated two facility owned fire hydrants are located near the front parking lot and acknowledged documentation of facility owned fire hydrant inspection within the last year was not available for review. Based on observations with the Maintenance Director and Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, two facility owned fire hydrants are located near the front parking lot.</p>		<p>There was not a particular resident identified to have been affected by the alleged practice. Integrated Electronics of Indiana Inc. have been contacted regarding the two fire hydrants for inspections. According to IEI, due to the winter weather temperature and conditions it is not possible to perform inspections on the fire hydrants until there are several days of above freezing temperatures. IEI anticipates being able to test both hydrants in mid to late March, weather permitting. If there is a break in the weather prior to March IEI will perform the inspection at that time. The one gauge at the sprinkler system riser has been replaced. II. The facility will identify other residents that may potentially be affected by the practice Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator regarding fire hydrant inspections and storage of the inspection documentation. A post- test will be utilized to ensure the maintenance staff and housekeeping manager</p>				

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, one of five gauges at the sprinkler system riser had a manufacture date of 2008. Based on interview at the time of observation, the Maintenance Director stated recalibration or replacement documentation for sprinkler system gauges was not available for review and acknowledged one of five sprinkler system gauges at the sprinkler system riser had exceeded the five year requirement for recalibration or replacement.</p>		<p>comprehend the requirement of fire hydrant inspections and the requirement of storing written records of fire hydrant inspections. The maintenance staff and housekeeping manager will be re-educated by the Administrator regarding automatic sprinkler system inspections and testing. The maintenance staff and housekeeping manager will be re-educated by the Administrator on storing written records of sprinkler system inspections and testing. A post-test will be utilized to ensure the maintenance staff and housekeeping manager comprehend the requirement automatic sprinkler system inspections and testing. The post-test was also utilized to ensure the maintenance staff and housekeeping manger comprehend the requirement of storing written records of automatic sprinkler system inspections and testing. The Maintenance Director or designee will ensure tests, inspections, and storage of written records for fire hydrant inspections are completed annually and after each operation. A task reminder will be inserted in to the TELS preventative maintenance program. The Maintenance Director or designee will ensure inspections, testing, and storage of written records for the automatic sprinkler system are completed</p>		

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	3.1-19(b)		<p>according to regulation requirements. A task reminder will be inserted in to the TELS preventative maintenance program. IV.The facility will monitor the corrective action by implementing the following measures.</p> <p>The Maintenance Director will notify and provide a copy of the written records of fire hydrant inspections when they are completed on an annual basis and after each operation to the Administrator. The Administrator or designee will audit the facility's maintenance records of fire hydrant inspections monthly. Any concerns will be addressed. The Maintenance Director will notify and provide a copy of the written records of automatic sprinkler system inspections and testing to the Administrator when they are completed. The Administrator or designee will audit the facility's maintenance records of automatic sprinkler system inspections and testing monthly. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be</p>		

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K010074 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure valences and window curtains in 9 of 9 smoke compartments were flame resistant. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:15 a.m. to 10:40 a.m. on 12/30/14, documentation of valence and window curtain flame resistant documentation was not available</p>	K010074	<p>responsible for ensuring the facility is in compliance by date of compliance listed.</p> <p>K 074 NFPA 101 LIFE SAFETY CODESTANDARD I.The corrective actions to be accomplished for those residents found to have been affected by the practice There was not a particular resident identified to have been affected by the alleged practice. The facility is currently updating the maintenance documentation of flame resistance for valence and window curtains. The facility will apply flame retardant applications to existing materials if documentation is not located. II. The facility will identify other</p>	01/29/2015

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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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	<p>for review. Based on observations with the Maintenance Director and Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, window valences and curtains installed in each smoke compartment had no affixed documentation stating each valence or curtain was inherently flame retardant. Based on interview at the time of record review and of the observations, the Maintenance Director stated valences and window curtains in the facility had not been treated with a flame retardant material and acknowledged valence and window curtain flame resistant documentation was not available for review.</p> <p>3.1-19(b)</p>		<p>residents that may potentially be affected by the practice Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator on the requirement of having flame resistant valence and window curtains and having documentation of the fire resistance for valences and window curtains. A post- test will be utilized to ensure the maintenance staff and housekeeping manager comprehend the requirement of having flame resistant valence and window curtains and documentation of the fire resistancy. The Maintenance Director or designee will store documentation of valence and window curtain flame resistance and will update records when new valences or curtains are installed. IV. The facility will monitor the corrective action by implementing the following measures. The Maintenance Director or designee will notify and provide a copy of the written record of valence and window curtain flame resistant documentation to the Administrator when new valences</p>		

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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>or curtains are installed. The Maintenance Director or designee will store copies of valence or curtain flame resistant documentation for the maintenance records. The Administrator or designee will audit 10 rooms every week for 30 days, then 5 rooms for 60 days, then 3 rooms quarterly for a total of 12 months to ensure valances and window curtains have documentation of flame resistancy. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p>	

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	<p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3,000 cubic feet was enclosed with separation of 1 hour fire resistive construction. This deficient practice could affect 8 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, four liquid oxygen containers were stored in the oxygen storage and transfilling room by Room 401. The south wall of the oxygen storage and transfilling room had an eight inch by three inch hole above the suspended ceiling for the passage of a two inch in diameter pipe which did not enclose the room with one hour fire resistive construction. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the south wall of the oxygen storage and transfilling room did not enclose the room with one hour fire resistive construction.</p> <p>3.1-19(b)</p>	K010076	<p>K 076 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the practice There was not a particular resident identified to have been affected by the alleged practice. The 3 inch hole above the suspended ceiling for the passage of a two inch in diameter pipe in the facility's only oxygen storage location has been repaired and the room is now enclosed with a one hour fire resistive construction. II. The facility will identify other residents that may potentially be affected by the practice Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator on ensuring oxygen storage locations of greater than 3,000 cubic feet are enclosed with separation of 1hour fire resistive construction. A post- test will be utilized to ensure the maintenance staff comprehend the requirement of a 1 hour fire resistive construction for the oxygen storage room. The</p>	01/29/2015	

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K010130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure 2	K010130	Maintenance Director or designee will ensure the oxygen storage location greater than 3,000 cubic feet is enclosed with separation of 1 hour fire resistive construction. IV. The facility will monitor the corrective action by implementing the following measures. The Maintenance Director or designee will audit the oxygen room 5 times a week for 30 days, then once a week for 60 days, and then monthly to ensure the oxygen room is enclosed with separation of 1 hour fire resistive construction. The Administrator or designee will audit the oxygen storage location 1 time a week for 1 month, then monthly to ensure the oxygen room is enclosed with separation of 1 hour fire resistive construction. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed. K 130 NFPA 101 MISCELLANEOUS I. The corrective actions to be	01/29/2015	

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	<p>of 2 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:15 a.m. to 10:40 a.m. on 12/30/14, two of two fuel fired water heaters, identified as Registration # 302363 and Registration # 289179, each had the expiration date of 09/27/14 listed on Certificate of Inspection documentation from the State of Indiana. Based on observations with the Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, current Certificate of Inspection documentation from the State of Indiana was not posted at each of the two fuel fired water heater locations. Based on interview at the time of record review and of the observations, the Maintenance Director and Housekeeping Manager stated each water heater should have current Certificate of Inspection documentation but acknowledged current</p>		<p>accomplished for those residents found to have been affected by the practice</p> <p>There was not a particular resident identified to have been affected by the alleged practice. The two fuel fired water heaters are scheduled to be inspected by CNA insurance and the facility will store and update the documentation of the inspection for both of the fuel fired water heaters. II. The facility will identify other residents that may potentially be affected by the practice</p> <p>Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator on the requirement of fuel fired water heaters inspected prior to the expiration date and to store documentation of the inspections. A post- test will be utilized to ensure the maintenance staff and housekeeping manager comprehend the requirement of completing fuel fired water heater inspections prior to the expiration date and to store documentation of the inspections. The Maintenance Director or designee will ensure fuel fired water</p>				

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K010143	Certificate of Inspection documentation was not available for review. 3.1-19(b) NFPA 101		heaters are inspected prior to the expiration date and documentation of the inspections are stored for the facility's records. This task will be added to the TELS preventative maintenance program. IV. The facility will monitor the corrective action by implementing the following measures. The Maintenance Director or designee will notify and provide a copy of the written record of fuel fired water heater inspections to the Administrator when the inspections are completed. The Maintenance Director or designee will have fuel fired water heater inspections completed prior to the expiration date and will store written copies of the inspection documentation. The Administrator or designee will audit the facility's maintenance records of fuel fired water heaters monthly. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.		

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SS=E	<p>LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling locations was separated from other spaces with a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 8 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, four liquid oxygen containers were stored in the oxygen storage and transfilling room by Room 401. The south wall of the oxygen</p>	K010143	<p>K 143 NFPA 101 LIFE SAFETY CODE STANDARD I. The corrective actions to be accomplished for those residents found to have been affected by the practice. There was not a particular resident identified to have been affected by the alleged practice. The 3 inch hole above the suspended ceiling for the passage of a two inch in diameter pipe in the facility's only oxygen storage location has been repaired and the room is now enclosed with a one hour fire resistive construction. II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice.</p>	01/29/2015			

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	<p>storage and transfilling room had an eight inch by three inch hole above the suspended ceiling for the passage of a two inch in diameter pipe which did not separate the room from other spaces with one hour fire resistive construction. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the south wall of the oxygen storage and transfilling room did not separate the room from other spaces with one hour fire resistive construction.</p> <p>3.1-19(b)</p>		<p>III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The maintenance staff and housekeeping manager will be re-educated by the Administrator on ensuring oxygen storage locations of greater than 3,000 cubic feet are enclosed with separation of 1 hour fire resistive construction. A post- test was utilized to ensure the maintenance staff comprehend the requirement of a 1 hour fire resistive construction for the oxygen storage room. The Maintenance Director or designee will ensure oxygen storage locations of greater than 3,000 cubic feet are enclosed with separation of 1 hour fire resistive construction. IV. The facility will monitor the corrective action by implementing the following measures. The Maintenance Director or designee will audit the oxygen room 5 times a week for 30 days, then once a week for 60 days, and then monthly to ensure the oxygen room is enclosed with separation of 1 hour fire resistive construction. The Administrator or designee will audit the oxygen storage location 1 time a week for 1 month, then monthly to ensure the oxygen room is enclosed with separation of 1 hour fire resistive construction. Any concerns will be addressed. The results of these reviews will be discussed at</p>		

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 42 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and Housekeeping Manager during a tour of the facility from 10:40 a.m. to 12:25 p.m. on 12/30/14, the following was noted:</p> <p>a. a telephone charger and a light lamp</p>	K010147	<p>the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.</p> <p>K 147 NFPA 101 LIFE SAFETY CODE STANDARD I.The corrective actions to be accomplished for those residents found to have been affected by the practice. The power strip in resident room 515 has been removed. The extension cord in resident room 517 has been removed. The power strip in the 100 Hall Nutrition Pantry has been removed. II. The facility will identify other residents that may potentially be affected by the practice. Residents who reside at Greenwood Health and Living Community, staff, and visitors have the potential to be affected by the alleged practice. III. The facility will put into place the following systematic changes to ensure that the practice does not recur. The</p>	01/29/2015

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	<p>were plugged into a power strip which was plugged into a power strip in resident Room 515.</p> <p>b. a light lamp was plugged into an extension cord in resident Room 517.</p> <p>c. a coffee pot was plugged into a power strip in the 100 Hall Nutrition Pantry. Based on interview at the time of the observations, the Maintenance Director and Housekeeping Manager acknowledged power strips and an extension cord were being used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p>		<p>maintenance staff and housekeeping manager will be re-educated by the Administrator that power strips and extension cords are not to be used as a substitute for fixed wiring. Staff members are being re-educated that power strips and extension cords are not to be used as a substitute for fixed wiring. A post- test was utilized to ensure the maintenance staff, housekeeping manager, and staff comprehend the requirement of power strips and extension cords are not to be used as a substitute for fixed wiring. Residents and family members/responsible parties will be notified through a letter explaining that power strips and extension cords are not to be used as a substitute for fixed wiring. Staff will ensure power strips and extension cords are not being used as a substitute for fixed wiring. IV. The facility will monitor the corrective action by implementing the following measures. The facility has been audited for power strips and extension cords and are not being used as a substitute for fixed wiring. The Maintenance Director or designee will audit 10 rooms a week for 30 days, then 5 rooms a week for 60 days, then 5 rooms monthly to ensure power strips and extension cords are not being used as a substitute for fixed wiring. The results of these reviews will be discussed at the monthly facility Quality Assurance</p>	

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			Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.		