

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155412	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2016
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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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K 0000 Bldg. 01	<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: 02/11/16</p> <p>Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620</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 smoke detectors installed in all resident sleeping rooms. The facility has</p>	K 0000		
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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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K 0038 SS=E Bldg. 01	<p>a capacity of 121 and had a census of 85 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 on 02/17/16 by Lex Brashear, LSC Specialist</p> <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 7 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</p>	K 0038	<p>Submission of this plan of correction in no way constitutes an admission by Greenwood Health & Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Life Safety Code Survey on February 11th, 2016. Please accept this plan of correction as</p>	03/14/2016

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	<p>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 delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect 20 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 11:20 a.m. to 12:50 p.m. on 02/11/16, the south exit door set in the South Dining Room to the exterior of the building was marked as a facility exit,</p>		<p>GreenwoodHealth & Living's credible allegation of compliance by March 14th,2016.</p> <p>Thisstatement of deficiencies and plan of correction will be reviewed at the March Quality Assurance/Assessment Committee meeting.</p> <p>Response to Survey Ending February 11th, 2016 K 038</p> <p>I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.</p> <p>20 residents could be affected by the deficientpractice.</p> <p>Vendor has been contactedand emergency egress lock has been ordered and set to be repaired by March 14th,2016</p> <p>II. The facility will identify other residentsthat may potentially be affected by the deficient practice The Facility Maintenance Staff were re-educated ontotics of ensuring that emergency egress doors meet 15 second releaserequirements related to</p>	

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	<p>was equipped with a delayed egress lock and was provided with necessary signage stating the door set could be opened in 15 seconds by pushing on the door release device but the exit door set failed to open within 15 seconds when the doors were pushed with the application of force three separate times. Based on interview at the time of the observation, the Maintenance Director stated the aforementioned exit is a facility exit, is equipped with a delayed egress lock and the necessary signage but acknowledged the exit door set failed to open within 15 seconds when the door set was pushed with the application of force three separate times.</p> <p>3.1-19(b)</p>		<p>Life Safety Code standards. The Maintenance Director and/ or Corporate Facilities Staff will physically inspect all emergency egressdoors to ensure proper operation of door locks and automatic lock releases.</p> <p>III. The facility will put into place the followingsystematic changes to ensure that the deficient practice does not recur.</p> <p>All emergency egress doorswill be audited monthly during fire drills to ensure proper release ofemergency egress door locks and that proper functionality is achieved per LifeSafety Code regulations.</p> <p>IV Thefacility will monitor the corrective action by implementing the followingmeasures.</p> <p>All monthly emergency doorlock release audits will be reviewed at the facility QAPI meeting which is heldmonthly to ensure repairs have been checked by the Maintenance Director orCorporate Facilities. Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency</p>	

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K 0062 SS=E Bldg. 01	<p>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</p> <p>Based on observation and interview, the facility failed to replace 3 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 25 residents, staff and visitors.</p> <p>Findings include:</p>	K 0062	<p>andduration of reviews will be adjusted as needed.</p> <p>V. Plan of Correction completion date. Plan of Completion date is March 14th, 2016. Administrator will be responsible to ensure complianceby date listed.</p> <p>K 062</p> <p>I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.</p> <p>25 residents could be affected by the deficientpractice.</p> <p>TheMaintenance staff has contracted with vendor to replace the 3 sprinkler headsthat were identified to be deficient by March 14th, 2016</p> <p>II. The facility will identify other residentsthat may potentially be affected by the</p>	03/14/2016

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	<p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 12:50 p.m. on 02/11/16, the pendant sprinkler installed in the closet for Room 113, 208 and 213 each had paint on them. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinkler locations each had paint on them.</p> <p>3.1-19(b)</p>		<p>deficient practice.</p> <p>The facility Maintenance staff were re-educated on ensuring all sprinkler heads are that have paint, corrosion, damage, loaded, or improper orientation are replaced by approved vendor in accordance with Life Safety Code standards.</p> <p>The Maintenance Director and/or Corporate Facilities Staff will physically inspect all sprinkler heads to ensure that there is no paint, corrosion, damage, loaded, or improper orientation.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>All sprinkler heads will be audited monthly during fire drills to ensure that there is no paint, corrosion, damage, loaded, or improper orientation and that proper functionality is achieved per Life Safety Code standards.</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p>	

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K 0076 SS=E Bldg. 01	<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</p>		<p>All monthly sprinkler head audits will be reviewed at the facility QAPI meeting which is held monthly to ensure that there is no paint, corrosion, damage, loaded, or improper orientation is checked by the Maintenance Director or Corporate Facilities.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is March 14th, 2016.</p> <p>Administrator will be responsible to ensure compliance by date listed.</p>	

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	<p>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 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 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 12:50 p.m. on 02/11/16, four liquid oxygen containers were stored in the oxygen storage and transfilling room by Room 401. The two inch annular space surrounding two, two inch in diameter sprinkler pipes which penetrated the north wall of the oxygen storage and transfilling room near the floor was not firestopped to enclose the room with one hour fire resistive construction. In addition, the one inch annular space surrounding a two inch in diameter sprinkler low point pipe which penetrated the ceiling of the aforementioned room also did not enclose the room with one hour fire resistive construction. The ceiling of the aforementioned room consisted of one</p>	K 0076	<p>K 076</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>10 residents could be affected by the deficient practice.</p> <p>The Maintenance staff has contracted with vendor to enclose oxygen room and all penetrated areas are constructed with the proper fire resistive construction material to ensure one hour fire resistive standard is met per Life Safety Code standards by March 14th, 2016.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>The Maintenance staff members were educated on the requirement for fire resistive standards and practices set forth by Life Safety Code.</p> <p>The Maintenance Director and/or Corporate Facilities Staff will</p>	03/14/2016

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	<p>layer of five-eighths inch drywall which also did not enclose the room with one hour fire resistive construction. Based on interview at the time of the observations, the Maintenance Director acknowledged one layer of ceiling drywall and the aforementioned holes in the north 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>		<p>physically inspect oxygen room for proper fire resistant construction.</p> <p>III. The facility will put into place the followingsystematic changes to ensure that the deficient practice does not recur.</p> <p>Oxygen Room will be audited monthly during fire drills to ensure that there is proper fire resistant construction and that proper functionality is achieved per Life Safety Code standards.</p> <p>IV The facility will monitor the corrective action by implementing the followingmeasures.</p> <p>Oxygen room audits will be reviewed at the facility QAPI meeting which is held monthly to ensure proper fire resistant construction is checked by the Maintenance Director or Corporate Facilities.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>	

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K 0143 SS=E Bldg. 01	<p>NFPA 101 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 enclosed with separation of 1 hour fire resistive construction. This deficient practice</p>	K 0143	<p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is March 14th,2016.</p> <p>Administrator will be responsible to ensure compliance by date listed.</p> <p>K 143</p> <p>I. The corrective actions to be accomplished for those residents found to have been</p>	03/14/2016

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	<p>could affect 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 12:50 p.m. on 02/11/16, four liquid oxygen containers were stored in the oxygen storage and transfilling room by Room 401. The two inch annular space surrounding two two inch in diameter sprinkler pipes which penetrated the north wall of the oxygen storage and transfilling room near the floor was not firestopped to enclose the room with one hour fire resistive construction. In addition, the one inch annular space surrounding a two inch in diameter sprinkler low point pipe which penetrated the ceiling of the aforementioned room also did not enclose the room with one hour fire resistive construction. The ceiling of the aforementioned room consisted of one layer of five-eighths inch drywall which also did not enclose the room with one hour fire resistive construction. Based on interview at the time of the observations, the Maintenance Director acknowledged one layer of ceiling drywall and the aforementioned holes in the north wall of the oxygen storage and transfilling room</p>		<p>affected by the deficient practice.</p> <p>10 residents could be affected by the deficientpractice.</p> <p>The Maintenance staff has contracted with vendor toenclose oxygen room and all penetrated areas with the proper fire resistiveconstruction material to ensure one hour fire resistive standard is met perLife Safety Code standards by March 14th, 2016.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>TheMaintenance staff members were educated on the requirement for fire resistivestandards and practices set forth by Life Safety Code.</p> <p>TheMaintenance Director and / or Corporate Facilities Staff will physicallyinspect oxygen room for proper fire resistant construction.</p> <p>III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not</p>	

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	<p>did not enclose the room with one hour fire resistive construction.</p> <p>3.1-19(b)</p>		<p>recur.</p> <p>Oxygen Room will be audited monthly during fire drills to ensure that there is proper fire resistant construction and that proper functionality is achieved per Life Safety Code standards.</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>Oxygen room audits will be reviewed at the facility QAPI meeting which is held monthly to ensure proper fire resistant construction is checked by the Maintenance Director or Corporate Facilities.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>V. Plan of Correction completion date.</p> <p>Plan of Completion date is March 14th, 2015</p> <p>Administrator will be responsible to</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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