

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155788	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/22/2014
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NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 N SR 135 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: 10/22/14</p> <p>Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Greenwood Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</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 smoke detectors hardwired to the fire alarm</p>	K010000	<p>November 6, 2014</p> <p>Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian St Indianapolis, IN 46204</p> <p>Dear Ms Rhoades,</p> <p>On October 22nd, 2014 a Life Safety Survey was conducted at Greenwood Meadows. Greenwood Meadows then respectfully requests this document be submitted as the Plan of Correction and be considered for desk review by the staff of your division.</p> <p>If any questions arise regarding this request or attached documents, please feel free to contact me at your earliest convenience.</p> <p>Respectfully submitted,</p> <p>Austin Steele, HFA</p> <p>Cc: Bernie McGuinness, VP of Operations Sue Hornstein, Director of Compliance Martha Herron, Director of Clinical Services File</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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K010029 SS=F	<p>system installed in all resident sleeping rooms. The facility has a capacity of 169 and had a census of 161 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/28/14.</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 Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 19 of 27 doors serving hazardous areas such as fuel fired heater rooms, central laundries greater than 100 square feet, physical plant maintenance shops and soiled linen and trash collection rooms</p>	K010029	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Facility placed an order on November 3rd, 2014 for 60 and 90 Minute Fire Rated Doors for the following rooms: Mechanical Rooms and the	11/03/2014

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	<p>each have a 3/4-hour fire protection rating. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Interior Doors Driftwood" documentation with the Executive Director and the Maintenance Director during record review from 9:10 a.m. to 11:10 a.m. on 10/22/14, the facility identified hazardous area doors which currently do not have a fire resistance rating of 3/4-hour. Based on review of Sanders Contracting & Management proposal dated 10/16/14 and Pro-Build purchase order estimate dated 10/08/14, the facility has obtained estimates to replace hazardous area doors identified in the aforementioned documentation. Based on observations with the Maintenance Director during a tour of the facility from 11:10 a.m. to 2:00 p.m. on 10/22/14, the following hazardous area entry doors each had a 20 minute fire resistance rating label affixed to the door or were not fire resistance rated:</p> <ol style="list-style-type: none"> Corridor door to the physical plant maintenance shop. Entry door to the natural gas fired dryer room in the Laundry. Corridor door to the natural gas fired furnace room by the Dining Room. 		<p>Laundry services room for the 100, 200, 300, 400, 500 Halls, Maintenance shop, Mechanical Room in Front Entry, Mechanical Room near activities, and Laundry room door. This description will cover door replacement of A-Q as indicated on the 2567. The order will take approximately 5-6 week for delivery. This will make the door available on or around December 12th. The facility will then need 3-4 days to paint and dry. Then installation should take a week bringing the completion date to December 26th 2014. · The two doors identified (Mechanical Room on the 500 hall and maintenance door) will be installed with the new door and self closures included How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· All residents have the potential to be affected by this alleged practice. All hazardous rooms have the potential to be affected by the alleged deficient practice. As the The Life Safety Code agent toured the building with ED and Maintenance Director, the agent identified doors that needed replacement. No other doors were identified needing replacement. · Maintenance director toured the building and ensured that all self closing doors closed correctly. This was also</p>				

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	d. Corridor door to the 300 Hall Laundry Services Room. e. Entry door to the mechanical room containing a natural gas fired furnace in the 300 Hall Laundry Services Room. f. Corridor door to the natural gas fired furnace room near the front entrance. g. Corridor door to the 100 Hall Laundry Services Room. h. Each of two entry doors to two mechanical rooms containing a natural gas fired furnace in the 100 Hall Laundry Services Room. i. Corridor door to the natural gas fired furnace room near the Activities Room. j. Corridor door to the natural gas fired furnace room near the nurses station. k. Corridor door to the 200 Hall Laundry Services Room. l. Entry door to the mechanical room containing a natural gas fired furnace in the 200 Hall Laundry Services Room. m. Corridor door to the natural gas fired furnace room near the Therapy Room. n. Corridor door to the 400 Hall Laundry Services Room. o. Entry door to the mechanical room containing a natural gas fired furnace in the 400 Hall Laundry Services Room. p. Corridor door to the 500 Hall Laundry Services Room. q. Each of two entry doors to two mechanical rooms each containing a natural gas fired furnace in the 500 Hall		completed with the Life Safety Inspection and only 2 doors identified during the tour. . What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Upon installation of the One Hour Fire Rated Doors, the deficient practice should not recur. No construction is planned that would affect any doors. · Maintenance director will check weekly the 27 doors to ensure that they doors open and self close appropriately. How will the corrective action be monitored to ensure the deficient practice will not occur? · The doors are scheduled to be replaced and after they are installed the deficient practice will not occur. · Maintenance director will report findings to the CQI meeting monthly x6 and quarterly thereafter.				

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	<p>Laundry Services Room.</p> <p>Based on interview at the time of record review and of the observations, the Executive Director and the Maintenance Director stated the facility currently does not have a date by which the doors will be replaced and acknowledged each of the aforementioned hazardous areas entry room doors had a 20 minute fire resistance rating label affixed to the door or were not fire resistance rated.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 27 hazardous areas such as fuel fired heater rooms and physical plant maintenance shops are equipped with self closing doors which latch into the door frame. This deficient practice could affect 34 residents, staff and visitors in the 500 Hall.</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 2:00 p.m. on 10/22/14, the following was noted:</p> <p>a. the mechanical room in the 500 Hall Dining Room contained one natural gas fired furnace and the entry door was equipped with a self closing device but</p>			
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	<p>the device failed to swing the door to self close.</p> <p>b. the corridor door to the Maintenance Shop in the service corridor was not equipped with a self closing device. Based on interview at the time of the observations, the Maintenance Director acknowledged each of the aforementioned hazardous areas were not equipped with a functional self closing device to self close and latch the door into the door frame.</p> <p>3.1-19(b)</p>				