STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELWOOD HEALTH AND LIVING	2300 PARKVIEW LN, ELWOOD, , 46036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
E 0000	Initial Comments An Emergency Preparedness Survey (EP) was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/13/25 Facility Number: 000372 Provider Number: 155522 AIM Number: 100289060 At this EP survey, Elwood Health and Living was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 85 certified beds. At the time of the survey, the census was 67. Quality Review completed on 03/14/25	E 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations in the survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegation of compliance.	
E 0006 SS = F	Plan Based on All Hazards Risk Assessment 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2),	E 0006	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	03/28/2025

	§441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment,		1. 1.)A Kaiser Permanente Hazard and Vulnerability Assessment tool was completed with current facility information. 2. 2.)All policies were reviewed to ensure there were policies to cover hazards for the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All occupants could have been affected by this deficient practice. 1. 1.)A Kaiser Permanente Hazard and Vulnerability Assessment tool was completed with current facility information. 2. 2.)All policies were reviewed to ensure there were policies to cover hazards for the facility. What measures will be put into place and what systemic changes will be made to ensure	

	including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and		that the deficient practice does not recur: The Kaiser Permanente Hazard and Vulnerability Assessment will be updated annually when the Emergency Plan is reviewed. The Maintenance Director will schedule the annual review and will, with coordination from the Administrator, ensure that the hazards and vulnerabilities assessment is completed and presented to the IDT team and will ensure there are policies in place for each hazard that facility is at risk for. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place: The Kaiser Permanente Hazard and Vulnerability Assessment will be updated annually when the Emergency Plan is reviewed. The Maintenance Director will schedule the annual review and will, with coordination from the Administrator, ensure that the hazards and vulnerabilities assessment is	

	community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and the Maintenance Director on 03/13/25 at 10:11 a.m., the EPP did list the top four hazards for the facility, but no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. Based on an interview at the time of record review, the Maintenance Director and the Administrator stated documentation of a risk assessment utilizing an all-hazards approach could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		completed and presented to the IDT team and will ensure there are policies in place for each hazard that facility is at risk for. All findings will be discussed in QAPI. QAPI team will discuss the need for further actions or to help develop policies and procedures if one is not currently in place.	
K 0000	INITIAL COMMENTS A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/13/25 Facility Number: 000372 Provider Number: 155522 AIM Number: 100289060 At this LSC survey, Elwood Health and Living was found not in compliance with Requirements for	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations in the survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its	

	Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has battery-operated smoke detectors in all resident sleeping rooms. The facility is partly protected by a TYPE II 65 Kw propane generator. The facility has a capacity of 85 and had a census of 67 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached storage building. Quality Review completed on 03/14/25		allegation of compliance.	
K 0211 SS = E	Means of Egress - General NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless	K 0211	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	03/28/2025

	modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 (#1) Based on observation and interview, the facility failed to maintain the means of egress through 1 of 8 exits egresses in accordance with LSC section 7.2.1.4.1 Swinging-Type Door Assembly Requirement states any door assembly in a means of egress shall be of the side-hinged or pivoted-swinging type, and shall be installed to be capable of swinging from any position to the full required width of the opening in which it is installed. (#2) Based on observation and interview, the facility failed to ensure 1 of 5 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 25 residents on the 300-hall. Findings include: (#1) Based on an observation with the Maintenance Director on 03/13/25 at 12:10 p.m., exit door #6 on the 300- hall did not open when tested due to the push-bar not working. On the door there was a handwritten sign stating, "Do not use door, Broken." The 300-hall did have other exits nearby less than 200 ft. away. Based on an interview at the time of observation, the Maintenance Director stated the exit door would not open due to the push-bar was broken, did repair the door to working condition, and that training was need for staff on how to request a work order if an exit door was not working.		1.)Exit door #6 was repaired while survey was still in progress. This deficient practice could have affected 25 residents on the 300 hall. 2.) 300 hall linen cart was removed from the hall and a new cart was purchased to keep linens in the shower rooms on each hall. This deficient practice could have affected 25 residents on the 300 hall. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: 1.) All residents had the potential to be affected by this deficient practice. Staff will be in-serviced on 3/25/25, on completing work orders timely to ensure maintenance director is aware of disrepair and able to correct in a timely manner. 2.) All residents had the potential to be affected by this deficient practice. All linen carts with linens more than 33 gallons	

	(#2) Based on an observation with the Maintenance Director on 03/13/25 at 12:15 p.m., in the 300-hall there was a clean linen cart that was stored in the hall during all three shifts. Based on an interview at the time of observations, the Maintenance Director stated the clean linen cart was stored in the 300-hall during all shifts and would have to find a new storage place for the cart. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		have been removed from the halls and new linen carts were purchased to keep linens in the shower room on each unit. All staff were in-serviced on this change on 3/25/25. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: 1. 1.)Maintenance Director will round facility weekly to ensure that all exits remain in good repair and will document results. This audit will be reviewed by the Administrator weekly to ensure compliance. 2. 2.)Housekeeping and Laundry Supervisor will round the facility weekly to ensure that all linen carts are stocked and in the shower rooms. This audit will be reviewed by the Administrator weekly to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

			IE what quality assurance program will be put into place: 1. 1.)Maintenance Director will audit each exit door weekly during rounding and turn in results to Administrator for review. Results of this audit will be discussed in QAPI. Audit will continue for one quarter or until 100% compliance is reached. Once 100% compliance is reached, Maintenance Director may request to reduce or discontinue this audit. 2. 2.) Housekeeping/Laundry Supervisor will audit each hall weekly during rounding and turn in results to Administrator for review. Results of this audit will be discussed in QAPI. Audit will continue for one quarter or until 100% compliance is reached. Once 100% compliance is reached, Housekeeping/Laundry Supervisor may request to reduce or discontinue this audit.	

K 0522 SS = E	HVAC - Any Heating Device NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the laundry room. Findings include: Based on an observation with the Maintenance Director on 03/13/25 at 12:39 p.m., the laundry room contained a fuel-fired dryer and a fuel-fired water heater without a fresh air intake to the room. This condition does not allow fresh air to enter the room. Based on an interview at the time of observation, the Maintenance	K 0522	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Maintenance Director removed a vent fan in the laundry room and added a section of flue to allow direct air from the outside to vent into the laundry room. The laundry room staff could have been affected by this deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: No residents were affected by this deficient practice, however, all laundry room staff could have been affected. The Maintenance Director removed a vent fan in the laundry room and added a section of flue to allow direct air from the outside to vent into the laundry room. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does	03/28/2025

	Director stated the fresh air intake was not located, and the fuel fired equipment was newer replacing an electrical dryer and an electrical water heater. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		not recur: The Maintenance Director audited all areas in the facility that use a gas source for a direct air vent. The laundry room and the mechanical room in dietary are the only two areas that use a gas source. The dietary mechanical room was in compliance as it has a direct air vent to the outdoors. If any power source (IE electric to gas) should occur in the facility, the Maintenance Director will observe for a direct air vent to ensure the facility remains in compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place: If any construction occurs in the facility, the Maintenance Director will inspect the area for any changes in power source that would require a direct air vent. Results from this inspection will be taken to QAPI for one quarter or until 100%	

			compliance is reached. Once 100% compliance is reached, Maintenance Director may request to reduce this audit or discontinue it at that time.	
K 0741 SS = F	Smoking Regulations NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where	K 0741	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: This deficient practice could have affected staff around the service exit and all residents using the main entrance. All discarded cigarettes were removed. No smoking signs were added to each exit in the facility. Communication was sent out to all families via Cliniconex (an automated message system) on 3/14/25, reminding all families that Elwood Health and Living is a tobacco free campus and there should be no smoking on the premises. Staff was also reminded on the Communication page on Point Click Care that the facility was a tobacco free campus on 3/14/25. An ashtray will be provided near the main entrance for all visitors to properly disposed of	03/28/2025

	smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff around the service exit and all residents using the main entrance. Findings include: Based on observations upon entrance to the building on 03/13/25 at 9:00 a.m. and with the Maintenance Director at 12:27 p.m., smoking on property was evident due to at least 30 cigarette butts on the ground around the main entrance to the building and 5 cigarette butts on the ground around the service hall exit. Based on records review at 1:10 p.m., the smoking policy stated smoking is not allowed on the facility's property. Based on an interview at the time of observation and records review, the Maintenance Director stated the facility is a non-smoking campus and confirmed there was smoking on property due to the cigarette butts on the ground outside the main entrance and the service exit. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		smoking materials prior to entering the facility. Staff were also re-educated on the smoking policy at the 3/25/25 In-service. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will audit the grounds weekly to ensure compliance. Results of audits will be submitted to the Administrator. If noncompliance is noted, education will be provided to those not following the facility policy. If noncompliance continues, visitors could have their visitation restricted from this facility. If staff is noted being noncompliant, disciplinary actions will result. How the corrective action(s) will be monitored to ensure the	

			deficient practice will not recur, IE what quality assurance program will be put into place: The Maintenance Director will bring results from this audit to QAPI to discuss with IDT members. Once one quarter or 100% compliance has been reached, Maintenance Director may request for this audit to be reduced or discontinued.	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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