STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/15/2025

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 No Information	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.	
K 0000	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/13/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/15/25 Facility Number: 000372 Provider Number: 155522 AIM Number: 100289060 At this PSR survey, Elwood Health and Living was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012	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 allegation of compliance.	

	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 72 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 04/16/25			
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	K 0741	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Communications were sent out to families on 4/16/25 reminding all families to dispose of all smoking materials properly when on facility grounds. We are a smoke free campus. All smoking materials need to be disposed of prior to entering**	04/23/2025

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 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, record review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff and visitors near the service hall exit.
Findings include:
Based on observation with the Administrator on 04/15/25 at 2:38 p.m., at least 9 cigarette butts were spewed on the ground near the service hall exit. Based on an interview at the time of observation, the Administrator

the grounds. We also have smoking receptacles at both entrances to ensure these products get disposed of properly. The housekeeping staff was inserviced on 4/16/25 about checking entrances daily to ensure no cigarette butts are on the ground. All staff was inserviced on this material again on 4/22/2025.

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 residents have the potential to be affected by this deficient practice. All discarded cigarettes were removed. Housekeeping was inserviced on 4/16/25 on daily rounding and keeping area free of smoking debris, families were reminded again of the facility policy. All staff were inserviced on 4/22/25 on the facility policy and proper disposal of smoking materials. A smoking receptacle was added to the back entrance to the facility.

What measures will be put into place and what systemic

	stated staff were not allowed to smoke of the property and the cigarette butts were from visitors using the service hall exit to visit residents in the Memory Care unit. Based on records review during the recertification survey at 1:10 p.m. on 03/13/25 with the Maintenance Director, the smoking policy stated smoking is not allowed on the facility's property. This finding was reviewed with the Administrator during the exit conference at 2:45 p.m.. This deficiency was cited on 03/13/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) Based on observation, record review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff and visitors near the service hall exit. Findings include: Based on observation with the Administrator on 04/15/25 at 2:38 p.m., at least 9 cigarette butts were spewed on the ground near the service hall exit. Based on an interview at the time of observation, the Administrator stated staff were not allowed to smoke of the property and the cigarette butts were from visitors using the service hall exit to visit residents in the Memory Care unit. Based on records review during the recertification survey at 1:10 p.m. on 03/13/25 with the Maintenance Director, the smoking policy stated smoking is not		**change will be made to ensure that the deficient practice does not recur?** The Maintenance Director or the Housekeeping Supervisor will audit entrances to the facility daily (M-F)for compliance. Results of audits will be submitted tot he Administrator. If non-compliance is noted, education will be provided to those not following the facility policy. If non compliance continues, visitors could have their visitation restricted from this facility. If staff is noted being non compliant, disciplinary action 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 and Housekeeping Supervisor will bring results from this audit to QAPI to discuss with IDT members. Once one quarter of 100% compliance is reached, Maintenance Director and Housekeeping Supervisor may request for this audit to be reduced or discontinued.**	

	allowed on the facility's property. This finding was reviewed with the Administrator during the exit conference at 2:45 p.m.. This deficiency was cited on 03/13/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		**We are requesting paper compliance. All proof of compliance has been attached.**	

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