STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/24/2023		
	ROVIDER OR SUPPLIER		2300 P	STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
E 0000 Bldg	conducted by the Irraccordance with 42 Survey Date: 05/24 Facility Number: 06 Provider Number: 100 At this Emergency Health and Living v Emergency Prepare Medicare and Medicare and Medicare and Medicare and Suppliers, 42 C capacity of 92 and 10 of this survey.	1/23 00372 155522	E 0000			
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w Department of Head 483.90(a). Survey Date: 05/24 Facility Number: 0 Provider Number: 1 AIM Number: 1002 At this Life Safety	Recertification and State vas conducted by the Indiana Ith in accordance with 42 CFR 4/2023 900372 155522 289060 Code survey, Elwood Health and not in compliance with	K 0000	Submission of this plan of correction shall not constitute be construed as an admission Elwood Health and Living that allegations in the survey reporaccurate or reflect accurately provisions of care and services the residents at Elwood Healt and Living. The facility request the following plan of correction considered its allegation of compliance.	the	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Penny R Broshar Administrator 06/07/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0ZZF21 Facility ID: 000372 If continuation sheet Page 1 of 20

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/24/2023
	PROVIDER OR SUPPLIER		2300 P	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN OD, IN 46036	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa	ty was determined to be of			
	sprinklered. The fa with smoke detection to the corridors and detectors in the resi	ruction and was fully cility has a fire alarm system on in the corridors, areas open battery operated smoke dent sleeping rooms. The ty of 92 and had a census of s survey.			
		-			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lightin Emergency lightin Emergency lightin duration is provide accordance with 7 18.2.9.1, 19.2.9.1	ng g of at least 1-1/2-hour d automatically in			
	Based on records refailed to ensure 1 of light was tested ann 7.9.3.1.1 (1) require conducted monthly, and a maximum of less than 30 seconds be conducted annual hours if the emerge powered and (5) Was	view and interview, the facility of 1 battery backup emergency ually for 90 minutes. Section is functional testing shall be with a minimum of 3 weeks weeks between tests, for not is, (3) Functional testing shall lly for a minimum of 1 1/2 may lighting system is battery written records of visual is shall be kept by the owner is authority having	K 0291	What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice? All residents had the potential be affected by this deficient practice. A form labeled "Anni Battery-Operated Emergency Light Test Form" was created	n to ual

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 2 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155522	B. W	ING		05/24/	2023
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIE	R		2300 P	ARKVIEW LN		
ELWOOI	D HEALTH AND LI	VING		ELWO	DD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	1 *	deficient practice could affect all			ensure that the 90 minute tes	-	
	residents in the fac	ility.			for the battery backup emerge	ency	
	Findings in deal				light is completed annually.	al to	
	Findings include:				Currently, the test is complete		
	Rosed on records r	eview with the Maintenance			the Maintenance Directors TE however, it does not indicate		
		23 at 10:45 a.m., annual testing			duration or date of completion		
		rup emergency lights was			new form will capture the loca		
	-	d on an interview at the time of			of where the test is performed		
		Maintenance Director stated			start time, stop time, duration		
		ate testing for the battery			test and date of test. This test		
		light has not been conducted			was completed on 5/25/23.		
	in the past 12 mont	2			The Administrator or designed	e will	
					audit for compliance one time		
	This finding was re	eviewed with the Administrator			monthly when ensuring the 30)	
	at the exit conferen	ice.			second test is completed. Aud		
					will also ensure that the 90 mi	inute	
	3.1-19(b)				testing for the battery backup		
					emergency light is completed		
					annually. Will add to QAPI to		
					ensure compliance for one ye	ar.	
					How other residents having	the	
					potential to be affected by the	ne	
					same deficient practice will		
					identified and what corrective	⁄e	
					action(s) will be taken?		
					All residents had the potential	to	
					be affected by this deficient		
					practice. A form labeled "Anni		
					Battery-Operated Emergency		
					Light Test Form" was created ensure that the 90 minute tes		
					for the battery backup emerge	•	
					light is completed annually.	люу	
					Currently, the test is complete	ed in	
					the Maintenance Directors TE		
					however, it does not indicate		
					duration or date of completion		
					new form will capture the loca		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/09/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155522	B. WING		05/24/2023	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF E	PROVIDER OR SUPPLIER	C	2300 P	ARKVIEW LN		
ELWOOI	D HEALTH AND LIV	/ING	ELWO	OD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				of where the test is performed	I, the	
				start time, stop time, duration	of	
				test and date of test.		
				The Administrator or designed		
				audit for compliance one time		
				monthly when ensuring the 30		
				second test is completed. Auc		
				will also ensure that the 90 mi	nute	
				testing for the battery backup		
				emergency light is completed		
				annually. Will add to QAPI to	or	
				ensure compliance for one ye	al.	
				What measures will be put in	nto	
				place and what systemic		
				change will be made to ensu	ire	
				that the deficient practice do	oes	
				not recur?		
				A form labeled "Annual		
				Battery-Operated Emergency		
				Light Test Form" was created	to	
				ensure that the 90 minute test	•	
				for the battery backup emerge	ency	
				light is completed annually.		
				Currently, the test is complete		
				the Maintenance Directors TE		
				however, it does not indicate t duration or date of completion		
				new form will capture the loca		
				of where the test is performed		
				start time, stop time, duration		
				test and date of test.	= -	
				The Administrator or designed	e will	
				audit for compliance one time		
				monthly when ensuring the 30		
				second test is completed. Aud		
				will also ensure that the 90 mi		
				testing for the battery backup		
				emergency light is completed		
				annually. Will add to QAPI to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0ZZF21

 ${\it Facility ID:} \quad 000372$

If continuation sheet

Page 4 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155522	A. BUILDING B. WING	01	COMPLETED 05/24/2023
	ROVIDER OR SUPPLIER O HEALTH AND LIV		2300 P	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN DD, IN 46036	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0363 SS=D Bldg. 01	than required enchexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containin combustible mater hardware. Roller la CMS regulation. Tapply to auxiliary sflammable or combused or combused or combused or combustible mater hardware.	ials have positive latching atches are prohibited by hese requirements do not spaces that do not contain		How the corrective action(s) will be monitored to ensure to deficient practice will not recur, IE what quality assurance program will be pinto place? Administrator or designee will report to the Quarterly QAPI meetings an will report on compliance with audit for completion of 90 minute annutest for emergency lighting. On one year of 100% compliance reached, QAPI Committee madiscuss the discontinuation of audit.	al nce is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 5 of 20

PRINTED: 06/09/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	TIPLE CONSTRUCTION (X3) DATE SURV			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01 </u>	COMPL		
		155522	B. WI	NG		05/24	/2023	
NAME OF I	PROVIDER OR SUPPLIE	D	-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	FROVIDER OR SUFFLIE	K		2300 P	ARKVIEW LN			
ELWOOI	D HEALTH AND LI	VING		ELWOOD, IN 46036				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRE		N (X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	doors complying	with 7.2.1.9 are permissible						
	if provided with a	device capable of keeping						
	the door closed w	when a force of 5 lbf is						
	applied. There is	no impediment to the						
	_	ors. Hold open devices that						
	release when the	door is pushed or pulled are						
	I •	ted protective plates of						
	unlimited height a	are permitted. Dutch doors						
	meeting 19.3.6.3	.6 are permitted. Door						
	frames shall be la	abeled and made of steel or						
	other materials in	compliance with 8.3,						
	unless the smoke	*						
	1 '	d fire window assemblies are						
	allowed per 8.3. I	n sprinklered compartments						
	there are no restr	rictions in area or fire						
	resistance of glas	ss or frames in window						
	assemblies.							
	19363 42 CFR	Parts 403, 418, 460, 482,						
	483, and 485							
		KS details of doors such as						
		ings, automatics closing						
	devices, etc.	inge, automaties sissing						
		ion and interview, the facility	K 0	363			06/28/2023	
		of 1 resident room corridor		202	What corrective action(s) wil	ı	30,20,2023	
		d with a means suitable for			be accomplished for those	-		
	_	losed, had no impediment to			residents found to have been	า		
		nd would resist the passage of			affected by the deficient			
		ient practice could affect 1			practice?			
	resident in room 1				One resident room was affected	ed		
					by this deficient practice. The			
	Findings include:				resident's bed was adjusted s	0		
					that the door was able to prop			
	Based on observati	ion with the Maintenance			latch.	,		
	Director on 05/24/2	23 at 1:20 p.m., the corridor door			An audit of all rooms has beer	า		
		12 would not close into the			completed to ensure no beds			

FORM CMS-2567(02-99) Previous Versions Obsolete

frame when tested. Based on interview at the time

of observation, the Maintenance Director agreed

the corridor door would not close into the door

frame because the bed was obstructing the

Event ID:

0ZZF21

Facility ID: 000372

impede the closure of resident

designee will audit all resident

rooms 1 times weekly to ensure

room door. The Administrator or

If continuation sheet

Page 6 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155522	B. W	ING		05/24/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NOVEDERIC N. AN OF CONDUCTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	opening. The finding was rev during the exit conf 3.1-19(b)	riewed with the Administrator Perence.			that all doors latch properly. O 100% compliance has been reached for 4 weeks, then aud will decrease to monthly. Administrator or designed will audit all resident rooms to ensithat door latches once a month 3 months or until 100% compliance is reached. Once 100% compliance is reached fone quarter, Administrator or designee will report to QAPI for possible discontinuation of audithis time.	lit ure h for or	
					How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident room, with the exception of private rooms or rehab suites, have to potential be affected by this deficient practice. All resident beds plain double occupancy rooms with measure no more than 88 ½ inches to ensure door closure. The Administrator or designed audit all resident rooms 1 time weekly to ensure that all doors latch properly. Once 100% compliance has been reached 4 weeks, then audit will decreate to monthly. Administrator or designed will audit all resident rooms to ensure that door latconce a month for 3 months or 100% compliance is reached. Once 100% compliance is	to ced ill s in for ase	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet Page 7 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 05/24/2023			
	PROVIDER OR SUPPLIER O HEALTH AND LIV		2300 P	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN DD, IN 46036	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	reached for one quarter, Administrator or designee will report to QAPI for possible discontinuation of audit at this time. What measures will be put in place and what systemic change will be made to ensure that the deficient practice doe not recur? All resident beds placed in dou occupancy rooms will measure more than 88 ½ inches if they placed on the side of the room with the door to ensure that the door latched properly. Any resident requiring a bed longer than 88 ½ inches will be placed the window side of a double occupancy room. The Administrator or designee audit all resident rooms 1 times weekly to ensure that all doors latch properly. Once 100% compliance has been reached 4 weeks, then audit will decrea to monthly. Administrator or designed will audit all resident rooms to ensure that door latch once a month for 3 months or of 100% compliance is reached. Once 100% compliance is reached for one quarter, Administrator or designee will report to QAPI for possible discontinuation of audit at this time.	to re es uble e no are d on will s for ase

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 8 of 20

PRINTED: 06/09/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	· ′	ILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/24/2023		
	PROVIDER OR SUPPLIE			2300 P	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN OD, IN 46036			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
K 0511 SS=D Bldg. 01	complies with NF Code, electrical v complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1.1 Based on observati failed to ensure 1 c interrupter (GFCI) protection against 2011 Edition at 21 Circuit-Interrupter states, ground-faul personnel shall be	d Electric gas or related gas piping PA 54, National Fuel Gas viring and equipment PA 70, National Electric stallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 Ion and interview, the facility of 1 ground fault circuit was properly maintained for electric shock. NFPA 70, NEC 0.8 Ground-Fault Protection for Personnel, t circuit-interruption for provided as required in 210.8. tice could affect 1 resident in	K 05	511	How the corrective action(s) will be monitored to ensure to deficient practice will not recur, IE what quality assurance program will be printo place? Administrator or designee will report to Quarterly QAPI result audits. Once 100% compliants has been reached for one qual QAPI Committee may discuss potential for discontinuation of audit at that time. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? One resident had the potential be affected by this deficient practice. An electrician was called and repair is scheduled.	the out Its of Secondary, Secon	06/28/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Based on observation with the Maintenance

Director on 05/24/23 at 1:20 p.m., when the GFCI

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Maintenance Director checked all GFI's in facility for good working

order. Maintenance Director or

designee will check all GFI's one

Page 9 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPLETED	
		155522	B. WING	·		05/24/20)23
NAME OF B	ADOLUDED OD GUDDI IED		S	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		2	2300 PA	ARKVIEW LN		
ELWOOD	D HEALTH AND LIV	/ING	E	ELWOC	DD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
		n the 300 Hall shower room			time monthly for three months	to	
		FCI tester the GFCI receptacle			ensure they remain in good		
	-	d not break the electrical			working order. Maintenance		
		terview at the time of			Director or designee will repor		
		intenance Director agreed the			Quarterly QAPI with results of		
	_	tacle did not properly work			audit. Once one quarter of 100		
	when tested.				compliance has been reached		
	The finding	vianuad vuith tha Advisitation			QAPI committee may discuss	tne	
	•	viewed with the Administrator			discontinuation of this audit.		
	during the exit conf	CICHCC.			How other residents having to potential to be affected by the	I	
	3.1-19(b)				-		
	3.1-19(0)				same deficient practice will ke identified and what corrective		
					action(s) will be taken?	e	
					All residents residing on the 30	20	
					hall had the potential to be	50	
					affected by this deficient pract	ice	
					An electrician was called and		
					repair is scheduled for 6-15-23	hne S	
					will be repaired.	, and	
					Maintenance Director checked	l all	
					GFI's in facility for good working	I	
					order. Maintenance Director o	-	
					designee will check all GFI's o		
					time monthly for three months		
					ensure they remain in good		
					working order. Maintenance		
					Director or designee will repor	t to	
					Quarterly QAPI with results of		
					audit. Once one quarter of 100		
					compliance has been reached	,	
					QAPI committee may discuss	the	
					discontinuation of this audit.		
					What measures will be put in	to	
					place and what systemic		
					change will be made to ensu	re	
					that the deficient practice do	I	
					not recur?		
					Maintenance Director will add	an	
1	l		Ī		Will add		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 10 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/24/2023
	OVIDER OR SUPPLIEI		2300 P	ADDRESS, CITY, STATE, ZIP COI ARKVIEW LN DD, IN 46036)
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY) annual audit to TELS reputed the consument of the consumen	DOOR DATE COMPLETION D
K 0761 SS=F Bldg. 01					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 11 of 20

JENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPLETED	
		155522	B. WI	NG		05/24	/2023
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
E1.14(0.0)	D	*** 10			ARKVIEW LN		
ELWOOI	D HEALTH AND LIV	/ING		ELWOC	DD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NAME CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.IE	DATE
	Based on records re	eview and interview, the facility	K 0'	761			06/28/2023
		ual inspection and testing of	12.0	701	What corrective action(s) wil	i	00/20/2023
		s were completed in			be accomplished for those	•	
		e requirements of NFPA 80,			residents found to have been	า	
		oors and Other Opening			affected by the deficient	•	
		80 5.2.1 states fire door			practice?		
		inspected and tested not less			Fire Door Inspection:		
		a written record of the			All residents had the potential	to	
	•	signed and kept for inspection			be affected by this deficient	iU	
	_	80, 5.2.3.1 states functional			practice. Facility Maintenance		
	1 -	and window assemblies shall					
	_	dividuals with knowledge and			Director completed Online Tra	iiiiig	
		_			for Inspection, Testing and		
		e operating components of			Maintenance of Swinging Fire		
		ng sbject to testing, NFPA 80,			Door Assemblies on 6/5/23.		
		oor assemblies shall be visually			Maintenance Director completed a fire door inspection of all fire doors		
		n sides to assess the overall			-	ioors	
		ssembly. NFPA 80, 5.2.4.2			on 6/6/23.	•••	
		n, the following items shall be			The Administrator or designee		
	verified:	1 1			audit Maintenance Log for the		
		or breaks exist in surfaces of			completion of Fire Door	••	
	either the door or fr				inspection. Results of this aud		
		light frames, and glazing beads			will be take to Quarterly QAPI		
		ely fastened in place, if so			reviewed for one year to ensu	re	
	equipped.				that fire door inspection is		
		e, hinges, hardware, and			completed. After one year of		
		eshold are secured, aligned,			compliance, Administrator or		
		er with no visible signs of			designee will discuss in Quart	•	
	damage.				QAPI for discontinuation of au		
	(4) No parts are mis				Rolling Fire Door in Dining Ro	om:	
	` '	do not exceed clearances			During the inspection, the		
	listed in 4.8.4 and 6				Maintenance Director and the		
		device is operational; that is,			Administrator were not certain		
		pletely closes when operated			the last inspection of the rolling	_	
	from the full open p				door (Serve out) in the main d	-	
		is installed, the inactive leaf			room. Upon further investigation		
	closes before the ac				was noted that this door was r		
		are operates and secures the			rolling fire door and would not		
	door when it is in the				require a tag. Attached (exhibi		
	(9) Auxiliary hardw	vare items that interfere or			shows that the main dining roo	om	

FORM CMS-2567(02-99) Previous Versions Obsolete

prohibit operation are not installed on the door or

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

is separated with a 2 hour rated

Page 12 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED		
		155522	B. W	B. WING		05/24/2023		
				CTREET	ADDRESS SITY STATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
FLWOOF		//N/O		2300 PARKVIEW LN				
ELWOOL	ELWOOD HEALTH AND LIVING			ELWO	OD, IN 46036			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	LOF CORRECTION (X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	frame.				fire barrier wall.			
	(10) No field modif	ications to the door assembly						
		ed that void the label.			How other residents having t	the		
	_	edge seals, where required, are			potential to be affected by th			
	, ,	their presence and integrity.			same deficient practice will be			
		ice could affect all residents.			identified and what correctiv			
	Time delicion piace				action(s) will be taken?	`		
	Findings include:				Fire Door Inspection			
	i manigo merade.				All residents had the potential	to		
	Based on record rev	view with the Maintenance			be affected by this deficient			
					practice. Facility Maintenance			
	Director (MD) on 05/24/23 at 11:45 a.m.,				Director completed Online Training			
	documentation of an annual inspection for the fire door assemblies was not available for review.				I The state of the			
	Based on interview at the time of records review,				for Inspection, Testing and			
					Maintenance of Swinging Fire			
		as not qualified to do a fire			Door Assemblies on 6/5/23.			
	_	an inspection has not been			Maintenance Director complet			
	completed in the las	st year.			fire door inspection of all fire d	oors		
	T1' C' 1'	. 1 4 4 4 1			on 6/6/23.			
	at the exit conference	viewed with the Administrator			The Administrator or designee			
	at the exit conference	ce.		audit Maintenance Log for the				
	2.1.10(1.)				completion of Fire Door	.,		
	3.1-19(b)				inspection. Results of this aud			
	.	1			will be taken to Quarterly QAP	Ί		
		on and interview, the facility			and reviewed for one year to			
		nnual testing of 1 of 1 rolling			ensure that fire door inspection	n is		
		ince with NFPA 80. LSC 4.5.8			completed. After one year of			
		, equipment, system,			compliance, Administrator or			
		nent, level of protection, or any			designee will discuss in Quart	- 1		
	_	ired for compliance with the			QAPI for discontinuation of au			
	_	ode, such device, equipment,			Rolling Fire Door in Dining Ro	om:		
		arrangement, level of			During the inspection, the			
	-	feature shall thereafter be			Maintenance Director and the			
		he Code exempts such			Administrator were not certain	of		
		A 80 5.2.1 requires fire door			the last inspection of the rolling	g		
		inspected and tested not less			door (Serve out) in the main d	ining		
	than annually, and a	a written record of the			room. Upon further investigation	on, it		
	inspection shall be	signed and kept for inspection			was noted that this door was r	not a		
	by the AHJ. This de	eficient practice could affect 25			rolling fire door and would not			
	residents in the mai	n dining room.			require a tag. Attached (exhibi	t A)		
					shows that the main dining roo	· ·		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet Page 13 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522		A. BUILDING <u>01</u> B. WING		COMPLETED 05/24/2023	
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING			2300 P	ADDRESS, CITY, STATE, ZIP COD PARKVIEW LN OD, IN 46036	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
		on with the Maintenance		is separated with a 2 hour ra	
	rolling fire door/windining room. There door to indicate whe performed and no desired and an interview Maintenance Direct had an inspection to there.	3 at 12:00 p.m., there was a ndow between the kitchen and was no tag on the rolling fire en the last annual test was ocumentation was provided. at the time of observation, the for stated the rolling fire door ag on it but it was no longer viewed with the Administrator ference.		What measures will be put place and what systemic change will be made to ensith the deficient practice of not recur? Fire Door Inspection: Facility Maintenance Direct completed Online Training for Inspection, Testing and Maintenance of Swinging Fire Door Assemblies on 6/5/23. Maintenance Director complifire door inspection of all fire on 6/6/23. Facility will ensure any future Maintenance Direct complete training for Inspect Testing and Maintenance of Swinging Fire Door Assemb The Administrator or designer audit Maintenance Log for the completion of Fire Door inspection. Results of this audit Maintenance Completed. After one year to ensure that fire door inspect completed. After one year to completed. After one year to complete will discuss in Quarterly	eted a doors ethat ectors tion, lies. ee will he lies ion is for arterly audit. Room: ale iin of ing dining ation, it

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 14 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155522	B. WING		05/24/2023		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWINEDIC DI ANI OF CORRECTION	(X5)		
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
				rolling fire door and would not require a tag. Attached (exhibit shows that the main dining root is separated with a 2 hour rate fire barrier wall.	it A) om		
				How the corrective action(s) will be monitored to ensure to deficient practice will not recur, IE what quality assurance program will be printo place? The Administrator or designee audit Maintenance Log for the completion of Fire Door inspection. Results of this aud will be taken to Quarterly QAP and reviewed for one year to ensure that fire door inspection completed. After one year of compliance, Administrator or designee will discuss in Quarter QAPI for discontinuation of au	ut will it l n is		
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemb assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g.,	ent - Power Cords and					

FORM CMS-2567(02-99) Previous Versions Obsolete

do not use PCREE. Power strips for PCREE

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 15 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/24/2023	
		100022	D. W.			03/24/	2023
	PROVIDER OR SUPPLIER D HEALTH AND LIV		STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036				
	SUMMARY (EACH DEFICIENT REGULATORY OF Meet UL 1363A of for non-PCREE in (outside of vicinity non-patient care mother UL standard used with general cords are not used wiring of a structutemporarily are recompletion of the installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3). Based on observation of the installed to ensure 1 of a substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for not be used for (1) and the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fixed equipment with a high NFPA-70/2011, 400 permitted in 400.7 for the substitute for fix	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION TO UL 60601-1. Power strips the patient care rooms by meet UL 1363. In coms, power strips meet dis. All power strips are precautions. Extension dias a substitute for fixed free. Extension cords used moved immediately upon purpose for which it was to the conditions of 10.2.4. dispute 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 for and interview, the facility for 1 power strip was not used as divining to provide power display current draw. display a substitute for fixed wiring, diexible cords and cables shall as a substitute for fixed wiring, diexible cords and cables shall as a substitute for fixed wiring, diexible cords and cables shall as a substitute for fixed wiring, diexible cords and cables shall as a substitute for fixed wiring.	K 0	2300 PA ELWOC ID PREFIX TAG	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All resident's on the 200 hall he the potential to be affected by deficient practice. Power strip was removed and mini fridge plugged into wall power source immediately at time of discover Maintenance Director or design will audit facility one time weel.	I n this was e erry.	(X5) COMPLETION DATE 06/28/2023
	with the Maintenance Director and Administrator on 05/24/23 at 1:00 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the 200 Nurses Station. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. The power strip was removed at the time of discovery. This finding was reviewed with the Administrator at the exit conference.				for power strips that are not permitted for the use of high current draw. Audit will continue for 2 weeks or until 100%		
					compliance is reached. Audit then reduce to 1 time monthly 1 quarter or until 100% compliance is reached. Result audit will be discussed at Quarterly QAPI. This audit will added to facility TELS and will continue indefinitely	for ts of l be	
	3.1-19(b)				How other residents having	the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0ZZF21 Facility ID: 000372 If continuation sheet Page 16 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/24/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN					
ELWOOD HEALTH AND LIVING				LWOO	D, IN 46036			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	(X5) MPLETION DATE	
					potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident's on the 200 hall he the potential to be affected by deficient practice. Power strip was removed and mini fridge to plugged into wall power source immediately at time of discover Maintenance Director or design will audit facility one time week for power strips that are not permitted for the use of high current draw. Audit will continue for 2 weeks or until 100% compliance is reached. Audit then reduce to 1 time monthly 1 quarter or until 100% compliance is reached. Result audit will be discussed at Quarterly QAPI. This audit will added to facility TELS to revie quarterly and will continue indefinitely. What measures will be put in place and what systemic change will be made to ensu that the deficient practice do not recur? All Staff will be educated on the facility policy for appropriate upower strips at All Staff inserving on 6/27/23. Facility will continue to enforce policy. Maintenance Director will add monthly rounding in facility to TELS to check for power strips being used for high current drawed in the power strips and the continue to the power strips and the power strips a	ad this was e erry. nee kly will for s of ll be w w to rees e se of ice ie		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

 ${\it Facility ID:} \quad 000372$

If continuation sheet

Page 17 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522		A. BUILDING B. WING	01	COMPLETED 05/24/2023			
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING			STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Gas Equipment - Transfilling of oxyganother is in according to Transfilling of High Oxygen Used for any gas from one prohibited in patie to liquid oxygen oxygen containers over 50 under 11.5.2.3.1 (liquid oxygen containers oxygen container	Transfilling Cylinders Transfilling Cylinders gen from one cylinder to rdance with CGA P-2.5, n Pressure Gaseous Respiration. Transfilling of cylinder to another is nt care rooms. Transfilling ontainers or to portable 0 psi comply with conditions NFPA 99). Transfilling to ainers or to portable	IAG	equipment. How the corrective action(s) will be monitored to ensure a deficient practice will not recur, IE what quality assurance program will be pinto place? Administrator or designee will audit weekly TELS for compliation one quarter. Findings will a discussed at Quarterly QAPI. Once compliance has been reached for one quarter, QAF committee may discuss in QAF for discontinuation of this audit was a committee of the commit	the out ance pe		
	conditions under 1 11.5.2.2 (NFPA 99 Based on observation failed to ensure 1 of the requirements of Facilities Code, 201 requires transfilling	on and interview the facility f 1 oxygen transfilling room met NFPA 99, Health Care 2 Edition, Section 11.5.2.3.1 to liquid oxygen base or to liquid oxygen portable	K 0927	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	n		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet

Page 18 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155522	B. WING 05/24/202			/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ARKVIEW LN		
EL MOOF) HEALTH AND LIV	/ING					
ELVVOOL	TIEALITI AND LIV	TING		ELWOC	DD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		ea separated from any portion			be affected by this deficient		
	of the facility where	ein patients are housed,			practice. Current fire door is o	nly	
		d by a fire barrier of 1 hour fire-			30 minute fire rated. Door will	be	
	resistant construction				replaced by a fire door that is	at	
		hanically ventilated, is			least 45 minutes fire rated on		
	-	s ceramic or concrete flooring.			6/8/23. Maintenance Director	or	
		ed with signs indicating that			designee has completed a fire		
		ring and that smoking in the			door inspection. All doors are		
	immediate area is n	•			rated appropriately at this time) .	
	* *	ransfilling the container(s) has			Maintenance Director or desig	nee	
		ed in the transfilling			will bring results of this audit to)	
	procedures.				Quarterly QAPI to review for		
	This deficient pract	ice could affect 10 residents in			compliance. Once one quarte	r of	
	the area.				compliance has been reached	,	
					QAPI committee may discuss	the	
	Findings include:				discontinuation of this audit.		
					How other residents having t	the	
		on during a tour of the facility		potential to be affected by the			
	with the Administra	ntor and Maintenance Director			same deficient practice will b	e	
	on 05/24/23 at 1:05	pm, the oxygen transfilling		identified and what corrective			
		nd to have a 1/2 hour			action(s) will be taken?		
	fire-rating. The room	m lacked separation by a fire	All residents had the potential to				
	barrier of 1 hour fir	e-resistive construction in that			be affected by this deficient		
		least a 45-minute fire-rated			practice. Current fire door is o	nly	
		Based on interview the			30 minute fire rated. Door will		
		for agreed the oxygen			replaced by a fire door that is	at	
	transfilling room do	oor has a 1/2 hour fire rating.			least 45 minutes fire rated on		
					6/8/23. Maintenance Director	or	
		viewed with the Administrator			designee has completed a fire		
	and Maintenance D	irector at the exit conference.			-	door inspection. All doors are	
					rated appropriately at this time		
	3.1-19(b)				Maintenance Director or desig		
					will bring results of this audit to)	
					Quarterly QAPI to review for		
					compliance. Once one quarte		
					compliance has been reached		
					QAPI committee may discuss	the	
					discontinuation of this audit.		
					What measures will be put in	ito	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0ZZF21

Facility ID: 000372

If continuation sheet Page 19 of 20

PRINTED: 06/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>		01	COMPLETED	
		155522	B. WING 05			05/24/2	2023
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING		STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		I	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPRO			COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
					place and what systemic		
					change will be made to ensu	ıre	
					that the deficient practice do		
					not recur?		
					Facility Maintenance Director		
					completed Online Training for		
					Inspection, Testing and		
					Maintenance of Swinging Fire	,	
					Door Assemblies on 6/5/23. V	Vhen	
					Maintenance Director comple	tes	
					his annual fire door inspectior	n, he	
					will also ensure that the corre	ct	
					fire rating in on fire doors.		
					Maintenance Director or design	gnee	
					will bring results of this audit t	ю.	
					Quarterly QAPI to review for		
					compliance. Once one quarte	er of	
					compliance has been reached	d,	
					QAPI committee may discuss	the	
					discontinuation of this audit.		
					How the corrective action(s)		
					will be monitored to ensure	the	
					deficient practice will not		
					recur, IE what quality		
					assurance program will be p	out	
					into place?		
					The Administrator or designed		
					audit Maintenance Log for the		
					completion of Fire Door Inspe		
					and rating. Once one quarter		
					compliance has been reached		
					QAPI committee may discus t	the	
					discontinuation of this audit.		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0ZZF21 Facility ID: 000372 If continuation sheet Page 20 of 20