STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155188	A. BUILDING -- B. WING	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/03/23 Facility Number: 000099 Provider Number: 155188 AIM Number: 100291140 At this Emergency Preparedness survey, Greenfield Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 163 certified beds. At the time of the survey, the census was 120. Quality Review completed on 10/05/23	E 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/03/23 Facility Number: 000099 Provider Number: 155188 AIM Number: 100291140 At this Life Safety Code survey, Greenfield	K 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Clark	Executive Director	10/20/2023

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.

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	Healthcare Center was found not in compliance with Requirements for Participation in 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 with a second story equipment area was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 163 and had a census of 120 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for four outside sheds which were used for storage. Quality Review completed on 10/05/23		paper compliance regarding alleged deficient practices.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all			

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	locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS			

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	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and Interview, the facility failed to ensure 1 of over 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 15 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/03/23 between 1 p.m. and 4:15 p.m., the main front exit door, marked as a facility exit, was magnetically locked and provided with signage stating the door was on a 15 second delayed egress lock. However, the delayed egress mechanism failed to	K 0222	**K 222** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. The facilities vendor came out and made adjustments to the front doors and installed new mag locks. Vendor had tested front doors along with maintenance director and front doors were functioning properly. 2. All residents have the potential to be affected by this alleged deficiency. The front doors have been fixed with new mag locks installed. Other egresses have been tested and checked to ensure compliance. 3. The Maintenance Director and maintenance assistant were both	10/21/2023

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	work when tested several times throughout the survey. The Maintenance Director stated the mechanism would need to be adjusted. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		educated with an emphasis on ensuring the locking mechanism is releasing the lock in the direction of egress within 15 seconds. 4. The Maintenance Supervisor and/or Designee will inspect monthly all egress doors with a 15 second delay to ensure the delayed egress mechanism can release the lock in the direction of egress within 15 seconds. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 10/21/2023	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door,	K 0293	**K 293** **Preparation and execution of this plan of correction does not constitute admission or**	10/21/2023

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	passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 8 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/03/23 between 1 p.m. and 4:15 p.m., door marked "17" to the outside courtyard was not an exit door and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the Maintenance Director stated the courtyard is not an exit to the public way and acknowledged the courtyard door did not have a "NO EXIT" sign posted. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		**agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.** **The facility cordially requests paper compliance regarding alleged deficient practices.** **1. Executive Director purchased a "NO EXIT" sign and new signage was placed on door marked 17.** **2. All residents have the potential to be affected by this alleged deficiency. New signage marked "NO EXIT" was placed in area cited. No other areas were noted during observation.** **3. The Executive Director, Maintenance Director, and Assistant Maintenance were educated by the Divisional Facilities Manager with an emphasis on signage to courtyard doors being marked with a "NO EXIT" sign to ensure the doors are not mistaken as a facility exit.** **4. The Maintenance Supervisor and/or Designee will inspect monthly all**	

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			courtyard doors to ensure the doors have a "NO EXIT" sign posted. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. **5. By what date will systemic changes be completed?** **10/21/2023**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9			

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	Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 5 of over 10 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 20 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/03/23 between 1 p.m. and 4:15 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) Resident Rooms #'s 331, 330, 329, 328, 327 which was larger than 50 square feet and contained construction material, paint and other combustible debris from the renovation of the rooms on the Rosewood Hall. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)	K 0321	**K 321** **Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.The facility cordially requests paper compliance regarding alleged deficient practices.1. Facility has installed self-closing devices on doors identified in hazardous rooms. 2. All residents have the potential to be affected by this alleged deficiency. The 5 doors identified as hazardous rooms all had self-closing devices installed by maintenance. Other doors were checked to ensure there were no other deficiencies.3. Doors are**	10/21/2023

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			checked monthly to ensure they close accordingly. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on having self-closing devices on doors in hazardous areas/rooms.4. The Maintenance Supervisor and/or Designee will ensure that doors are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached.5. By what date will systemic changes be completed? 10/21/2023	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under			

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	18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff and visitors. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/03/23 between 1 p.m. and 4:15 p.m., the design of the kitchen hood requires two drip trays, one on each side. Only the right side contained a drip tray, the left side was missing its metal drip tray underneath the kitchen range hood system. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance	K 0324	**K 324** **Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.** **The facility cordially requests paper compliance regarding alleged deficient practices.** **1. Maintenance Director found drip tray to the kitchen range hood system and was re-installed.** **2. All staff and visitors have the potential to be affected by this alleged deficiency. The metal drip tray that was missing from the left side was re-installed underneath the kitchen range hood system.**	10/21/2023

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	Director and Executive Director present. 3.1-19(b)		**3. The Maintenance Director and/or Designee will perform monthly checks to ensure the drip trays are present underneath the kitchen range hood system. Maintenance Director/assistant were educated on both drip trays being required for the kitchen hood system.** **4. The Maintenance Supervisor and/or Designee will ensure that the drip trays for the kitchen range hood system are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached.** **5. By what date will systemic changes be completed?** **10/21/2023**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance,			

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	inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on records review and interview with the Executive Director and the Maintenance Director	K 0353	**K353** **Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.** **The facility cordially requests paper compliance regarding alleged deficient practices.** **1. Sprinkler Company performed a full hydrostatic flush with repairs done accordingly. Facility remained under Fire Watch until Sprinkler Company completed flush/repairs and system was restored.** **2. All residents, staff, and visitors have the potential to be**	10/21/2023

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	on 10/03/23 between 10:20 a.m. and 12:48 p.m., the Internal Pipe Inspection from the facilities vendor dated 07/02/20 stated the facility contractor "performed a 5-year Internal Pipe Inspection and on the "System # 2 Crossmain found to have rust along the bottom of the pipe and the branch line has minimal rust. Based on inspection results for those areas inspected, recommend that mains and cross-mains be flushed for this system." During the interview the Executive Director and the Maintenance Director stated that they were recently made aware of this issue (within the last 2 months) and had been seeking bids to accomplish the work. After interview, the facility began a fire watch and contacted a new contractor who is now scheduled to flush the aforementioned system on 10/05/23. Receipts for the scheduled work were provided. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)		**affected by this alleged deficiency. The sprinkler flush was completed. Maintenance Director/Assistant, and Executive Director were educated by Divisional Facilities Manager with an emphasis on Maintenance and Testing Automatic sprinkler and standpipe systems. To ensure systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, testing, and Maintaining of Water-based Fire Protection Systems** **3. The maintenance director will send all sprinkler inspection documents to the Divisional facility manager for review after inspections are completed to ensure all inspection deficiencies are resolved.** **4. The Maintenance Supervisor and/or Designee will ensure that sprinklers/sprinkler system are maintained per NFPA 25, Standard for the Inspection, testing, and Maintaining of Water-based Fire Protection Systems. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance has not been achieved by the end of the 6 months, then the monitoring will continue until this**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 01 B. WING	10/03/2023

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			threshold has been reached. **5. By what date will systemic changes be completed?** **10/21/2023**	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire			

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	resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 60 corridor doors would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 10/03/23 between 1 p.m. and 4:15 p.m., the corridor door to RR 329 was missing a latching device and had a hole which penetrated completely through the door where the latching device was missing. The Maintenance Director stated that the painters likely failed to reinstall the hardware. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)	K 0363	**K363** **Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.** **The facility cordially requests paper compliance regarding alleged deficient practices.** **1. The door identified in alleged deficiency was fixed by the maintenance staff. Door knob was removed to have door painted. A new door knob was installed on door in resident room 329 where cited.** **2. All residents, staff, and visitors have the potential to be affected by this alleged deficiency. Maintenance Director inspected other doors with no issues identified. Maintenance**	10/21/2023

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			Director/assistant were educated by Executive Director with an emphasis on doors being able to resist the passage of smoke. **3. Maintenance and /or Designee will make rounds monthly to ensure corridor doors have no issues and resist the passage of smoke. Maintenance staff educated on corridor doors resisting the passage of smoke.** **4. The Maintenance Supervisor and/or Designee will ensure that other corridor doors resist the passage of smoke. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached.** **5. By what date will systemic changes be completed?** **10/21/2023**	