STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155026	A. BUILDING -- B. WING	09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD VILLAGE SOUTH	295 VILLAGE LANE GREENWOOD, IN 46143

(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: 09/11/23 Facility Number: 000010 Provider Number: 155026 AIM Number: 100453660 At this Emergency Preparedness survey, Greenwood Village South was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 137 certified beds. At the time of the survey, the census was 119. Quality Review completed on 09/14/23	E 0000		
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: 09/11/23 Facility Number: 000010 Provider Number: 155026 AIM Number: 100453660 At this Life Safety Code survey, Greenwood	K 0000	Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. Greenwood Village South reserves the right to challenge, in legal proceedings, all deficiencies, statements, findings and facts and conclusions that	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Seegers	Administrator	09/27/2023

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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	Village South 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) and 410 IAC 16.2. Building 0101 was surveyed using Chapter 19, Existing Health Care Occupancies. This one story facility was surveyed as two separate buildings due to the construction dates of the two sections of the building. Building 0101 was constructed in 1996 and was determined to be a one story facility of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Building 0101 has smoke detectors hard wired to the building electrical system installed in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 119 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/14/23		form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health			

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	care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on record review, observation and interview; the facility failed to maintain the 2-hour fire rated separation between the skilled nursing unit and the attached assisted living area in accordance with Section 19.1.3.4.1. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the main entrance lobby. Findings include: Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, the self closing devices on the door set in the foyer outside the main entrance lobby had been removed. The door set was in the fully open position and the fire resistance rating of the glass door set could not be determined. The door set in the foyer leads to the first floor lobby of the adjoining assisted living area. A stairwell door in the first floor lobby of the adjoining first floor assisted living area was in the closed position but was not equipped with a fire resistance rating label and the latching mechanism for the stairwell	K 0131	1. No residents were affected by the door between the skilled nursing building and the adjoining lobby area leading to the skywalk to the Independent Living building lacking a latching device and lacking a fire rating label. 2. The facility understands the residents in the facility could be affected by the door between the skilled nursing building and the adjoining lobby leading to the skywalk to the Independent Living building lacking a latching device and lacking a fire rating label. 3. Central Indiana Hardware has been scheduled to do an onsite visit to certify that the area of separation between the health center and the skywalk leading to the Independent Living building has the appropriate fire rating. 4. Plant Operations Health Care Supervisor, or his designee, will ensure this door is added to the annual fire door inspection audit	10/20/2023

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	door was in the "dogged down" position. As a result, it was unclear where the tenant separation wall was which separated the skilled nursing unit and the attached assisted living area. Based on interview at the time of the observations, the Assistant Director of Plant Operations stated the facility was in the process of reconfiguring the foyer but agreed it was unclear where the tenant separation wall was which separated the skilled nursing unit and the attached assisted living area. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)		and will present this audit to the QAPI committee for review.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General 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 modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 8 means of egress in the Dogwood wing 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 over 50 residents, staff and visitors in the Dogwood wing if needing to exit the facility. Findings include:	K 0211	1. No residents were affected by the bed, chairs, lifts and wheelchairs lined up on the edges of the two hallways connecting the Dogwood Front unit with the Dogwood Back unit. 2. Although the two cited hallways are not normally used as a public means of egress, the facility understands that all residents, visitors and staff have the potential	10/13/2023

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	Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, a resident bed, four upholstered chairs, Hoyer lifts, furniture and wheelchairs were stored all along the south side of the corridor in the north corridor of the Dogwood wing outside Room 211 and Room 217. The storage of the aforementioned items was all along the entire length of the corridor. The storage of the bed in the corridor reduced the clear and unobstructed width of the eight foot wide corridor to less than four feet. The north corridor of the Dogwood wing had a double door set to the outside of the facility which was marked as a facility exit with an exit sign. In addition, a resident bed, upholstered chairs, Hoyer lifts, furniture and wheelchairs were stored all along the north side of the corridor in the south corridor of the Dogwood wing outside Room 107 and Room 113. The storage of the aforementioned items was all along the entire length of the corridor. The storage of the bed in the corridor reduced the clear and unobstructed width of the eight foot wide corridor to less than four feet. Based on interview at the time of the observations, the Assistant Director of Plant Operations agreed the aforementioned means of egress were not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)		to be affected in the event of an emergency where these items could be considered obstacles. 3. The two cited hallways have been cleared of furniture. 4. Plant Operations Health Care Supervisor or his designee will audit the corridors to assure hallways are kept clear of furniture one time per week for 1 month, then one time per month for an additional 11 months. Audits will be presented to and reviewed by the QAPI committee during the monthly QAPI meeting.	

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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 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 1 of over 14 hazardous areas such as soiled linen rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing	K 0321	1. No residents were affected by the cited door to the soiled utility room not being equipped with the latching hardware to latch the door into the doorframe.	09/27/2023

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	or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Sycamore wing Soiled Linen room by Room 219. Findings include: Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, the Sycamore wing Soiled Linen room by Room 219 was equipped with two door leafs serving as the corridor door set to the room. Each door leaf was equipped with a self closing device but the inactive door leaf in the door set failed to latch into the door frame when tested to close multiple times. The latching device at the top of the inactive leaf failed to protrude and latch into the door frame when tested to close multiple times. Two 32-gallon capacity carts each partially filled with soiled linen were stored in the room. Based on interview at the time of the observations, the Assistant Director of Plant Operations stated the inactive leaf is supposed to latch into the door frame but agreed the latching mechanism would not protrude into the door frame and agreed the soiled linen storage room was not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)		2. The facility understands that residents in the facility could be affected by the door not fully latching into the door frame in the event of a fire in that area. Plant Operations staff has replaced the latching hardware piece of the cited door so that it latches properly when it is closed. 3. The facility has added the latching hardware to the cited door so that it latches properly. 4. Plant Operations Health Care Supervisor, or his designee, will audit this soiled utility room door one time monthly for 12 months to assure both doors are properly latched when closed. Audits will be presented to and reviewed by the QAPI committee during the monthly QAPI meeting.	
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	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, 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 observation and interview, the facility failed to maintain the ceiling construction in 1 of 8 exterior canopies. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 20 residents, staff, and visitors in the vicinity of Room 109 in the Dogwood wing. Findings include: Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, a three	K 0353	1. No residents or staff were affected by the 3-inch gap around the escutcheon in the exterior soffit. 2. The facility understands that staff and residents in the vicinity of that exterior soffit have the potential to be affected by the hole in the soffit possibly causing a delay in the sprinkler head activation during a fire. 3. The gap in the exterior soffit has been fixed. 4. Plant Operations Health Care Supervisor, or his designee, will audit the exterior soffits where sprinkler heads are present to assure there are no holes in the soffits. Audits will occur monthly for 1 year and be presented to and reviewed by the QAPI committee	09/27/2023

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	inch hole was noted in the soffet on the underside of the exterior canopy outside the south exit door of the facility by Room 109 in the Dogwood wing which would delay activation of the one pendant sprinkler mounted on the ceiling of the canopy. Based on interview at the time of the observation, the Assistant Director of Plant Operations agreed the hole in the underside of the south exterior canopy would delay activation of the sprinkler. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)		monthly.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 2 of 2 new weigh scale areas were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and	K 0361	1. No residents or staff were affected by the fact that the open room, still under construction and intended for housing the wheelchair scale had only a sprinkler head and not a smoke detector. 2. The facility understands that all facility staff and residents near those areas have the potential to be affected by not having a smoke detector in these areas. 3. The smoke detector has been	10/13/2023

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	(b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, the Sycamore wing and the Dogwood wing shower areas each had undergone recent renovations which included reducing the size of the shower rooms but created adjoining areas which now open to the corridor. The open spaces were fully sprinklered but were not observable from the nurse's station and did not have electrically supervised automatic smoke detection. Based on interview at the time of the observations, the Assistant Director of Plant Operations stated the open spaces were created for weigh scale areas and agreed the newly opened spaces to the corridor were not protected by an electrically supervised automatic smoke detection system. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)		installed in each of the rooms where the wheelchair scale is stored. Aadco will complete the set up to connect to the fire alarm system by 10/13/2023. 4. Plant Operations Health Care Supervisor, or his designee, will audit all current areas that are being remodeled to assure that all areas that are going to be used for the same or similar purposed have a smoke detector installed. Audits will occur monthly for 1 year and be presented to and reviewed by the QAPI committee monthly.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled			

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	for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 3 smoke compartments in the Dogwood wing was maintained in accordance with 19.7.5.6. 19.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 19.7.5.6(b), (c), or (d).	K 0753	1. No residents were affected by the presence of the Halloween decoration on the resident's door that was not labeled as flame retardant. 2. The facility understands the residents and staff in the area near resident room 212 had the potential to be affected by the Halloween decoration that was not labeled as flame retardant in the event of a fire. 3. The Halloween decoration was removed immediately during the Life Safety inspector's tour of the facility with the Plant Operations Management. 4. Plant Operations Health Care Supervisor, or his designee, will audit all resident room door decorations to assure they are labeled flame retardant or do not cover in excess of 30% of the door surface. Audits will occur monthly for 1 year and be reported to the QAPI committee monthly.	09/27/2023

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	(b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (5)*They are decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 212 in the Dogwood wing. Findings include: Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, plastic sheeting and other miscellaneous combustible Halloween decorations were hung on or affixed to corridor door to Room 212 in the Dogwood wing and covered more than 70% of the face of the corridor side of the door. Neither the plastic film nor the Halloween decorations had affixed documentation indicating the material was fire retardant or fire retardant treated. Based on interview at the time of the observations, the			

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	155026	A. BUILDING 01 B. WING	09/11/2023

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	Assistant Director of Plant Operations stated he was not aware if the affixed decorations had been treated with fire retardant material and agreed fire resistance rating documentation for the decorations was not available for review and removed the decorations from the door. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and			

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	results. 6.3.4 (NFPA 99) Based on record review and interview, the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This deficient practice could affect all residents. Findings include: Based on review of "Receptacle Testing" documentation dated March 8th to March 10th, 2022 with the Assistant Director of Plant Operations and the Plant Operations Supervisor during record review from 9:00 a.m. to 12:40 p.m. on 09/11/23, electrical receptacle inspection and	K 0914	1. No residents or staff were affected by the non-hospital grade electrical receptacle annual testing not being completed in a timely manner. The last annual inspection was completed 3/10/2022. 2. The facility understands that all residents and staff have the potential to be affected by the non-hospital grade electrical receptacle annual testing not being completed in a timely manner. 3. The non-hospital grade electrical receptacle annual testing will be completed by 10/13/2023. 4. Plant Operations Health Care Supervisor, or his designee, will present the completed annual testing to the QAPI committee for review and assure that the next annual testing is scheduled to be completed before 10/13/2024. The scheduled date for the 2024 testing will be presented to the QAPI committee before 09/01/2024 so that we can assure compliance is maintained.	10/13/2023

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	testing documentation within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Assistant Director of Plant Operations stated each resident sleeping room has multiple receptacle locations some of which may be hospital-grade but agreed electrical receptacle inspection and testing documentation for the most recent twelve month period was not available for review. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed			

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	wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 414 in the Sycamore wing. Findings include:	K 0920	1. No residents were affected by the use of the power strip in room 404 used for two cell phone chargers and the one in the unit manager's office used for a lamp and coffee maker. 2. The facility understands that all residents have the potential to be affected by the use of power strips in patient care areas. 3. Both power strips were removed and education provided to staff, residents and resident family members. 4. Plant Operations Health Care Supervisor, or his designee, will audit one of four nursing units per week, so that every resident room is checked one time per month to make sure there are no power strips, extension cords and multiplug adapters. Audits will occur monthly for 1 year and be presented to and reviewed by the QAPI committee monthly.	09/27/2023

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	Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, two cell phone charging cables were plugged into a power strip placed on the floor within three feet of a resident bed in Room 414 in the Sycamore wing. The power strip was placed in between two upholstered chairs. The UL listing of the power strip could not be determined. In addition, a coffee pot and a lamp were plugged into a power strip in the Sycamore wing Nurse Manager Office. Based on interview at the time of the observations, the Assistant Director of Plant Operations agreed a power strip was being used in the patient care vicinity for non-PCREE in Room 414 and as a substitute for fixed wiring in the Sycamore Nurse Manager Office. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable			

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	containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99, Health Care Facilities, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Dogwood wing oxygen storage and transfilling room by Room 201. Findings include: Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, the ceiling mounted exhaust fan in the Dogwood wing oxygen storage and transfilling room by Room 201 was not in operation. Six liquid oxygen containers and two 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Assistant Director of Plant Operations agreed the ceiling mounted exhaust fan was inoperable. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference. 3.1-19(b)	K 0927	1. No residents were affected by the exhaust fan in the Dogwood O2 room not working. 2. The facility understands that the residents and staff near the Dogwood O2 room had the potential to be affected by the exhaust fan not working. 3. The exhaust fan in the Dogwood O2 storage room has been replaced. 4. Plant Operations Health Care Supervisor, or his designee, will audit both O2 storage rooms (Dogwood and Redbud) to ensure the mechanical ventilation and exhaust fans are working properly. Audits will occur monthly for 1 year and be presented to and reviewed by the QAPI committee monthly.	09/27/2023

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K 0000 Bldg. 03	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: 09/11/23 Facility Number: 000010 Provider Number: 155026 AIM Number: 100453660 At this Life Safety Code survey, Greenwood Village South 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) and 410 IAC 16.2. Building 0103 was surveyed using Chapter 18, New Health Care Occupancies. This one story facility was surveyed as two separate buildings due to the construction dates of the two sections of the building. Building 0103 was constructed in 2019 and was determined to be a one story facility of Type V (111) construction and was fully sprinklered. Building 0103 consists of the new addition which includes the Therapy room, Utility room, Nurse's station, a semi private Therapy room, Restroom, two Private Therapy rooms and a Therapy Kitchen. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and has smoke detectors hard wired to the building electrical system installed in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 119 at the time of this visit.	K 0000		

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	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/14/23			
K 0361 SS=E Bldg. 03	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 18.3.6.1. LSC 18.3.6.1 states corridors shall be separated from all other areas by partitions complying with 18.3.6.2 through 18.3.6.5 (see also 18.2.5.4), unless otherwise permitted by one of the following: (1) Spaces shall be permitted to be unlimited in area and open to the corridor, provided that all of the following criteria are met: (a)*The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers.	K 0361	1. No residents were affected by the double doors to the therapy gym rubbing together and not closing and latching properly. 2. The facility understands residents and staff near the therapy gym had the potential to be affected by the door rubbing together and not latching properly. 3. The door has been fixed so that it closes and latches properly. 4. Plant Operations Health Care Supervisor, or his designee, will audit the double doors to the therapy gym to assure the doors are fully closing and latching properly. Audits will be weekly for one month and monthly for an additional 11 months and be presented to and reviewed by the QAPI committee monthly.	09/27/2023

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	(c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses ' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room. Findings include: Based on observations with the Assistant Director of Plant Operations and the Plant Operations Supervisor during a tour of the facility from 12:40 p.m. to 3:40 p.m. on 09/11/23, each door in the corridor door set serving as the entrance to the new Therapy Room did not fully close and latch into the door frame when tested to close multiple times. Each door was equipped with a self closing device and each door in the corridor door set was held open by magnetic hold open devices set to release with fire alarm system activation. The meeting edges of the two doors kept hitting each other which prevented the doors from fully self closing and latching into the door frame when tested to close multiple times. Based on interview at the time of the observations,the Assistant Director of Plant Operations agreed the corridor door set serving as the entrance to the new Therapy Room did not fully close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Administrator, the Assistant Director of Plant Operations and the Plant Operations Supervisor during the exit conference.			

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