| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155783 | A. BUILDING **02**<br>B. WING _____ | R<br>**10/31/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GREENLEAF HEALTH CAMPUS** | **1201 E BEARDSLEY AVE**<br>**ELKHART, IN 46514** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS<br><br>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/30/22 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).<br><br>Survey Date: 10/31/22<br><br>Facility Number: 002661<br>Provider Number: 155783<br>AIM Number: 201056540<br><br>At this PSR survey, Greenleaf Health Campus was found 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.<br><br>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The building was constructed in 2010, is adjacent to an assisted living unit and separated by a Fire Wall with a two-hour Fire Resistive Rating. The facility has a fire alarm system with smoke detection in corridors, in areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility is partially protected by a 150 kW Natural Gas Generator. The facility has a capacity of 60 beds and had a census of 54 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered. The facility had an | {K 000} | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| {K 000} | Continued From page 1<br>unsprinklered garage providing storage of maintenance supplies.<br><br>Quality Review completed on 11/01/22 | {K 000} | | |