	AID SERVICES			OMB NO. 0938-039		
			ONSTRUCTION	(X3) DATE SURVEY		
OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
	155788	B. WING	10/07/2024			
PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATE ROAD 135 GREENWOOD, IN 46142				
SHMMARV	STATEMENT OF DEFICIENCIE	ID		(X5)		
			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			
`			CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
REGULATURI OR	CESC IDENTIFTING INFORMATION	IAG		DATE		
conducted by the In accordance with 42 Survey Date: 10/07 Facility Number: 0 Provider Number: 2010 At this Emergency In Greenwood Meadowith Emergency Promotes and Medicare and Medicare and Medicare and Suppliers, 42 Company The facility has 169	diana Department of Health in CFR 483.73. 7/24 12564 155788 018510 Preparedness survey, ws was found in compliance eparedness Requirements for caid Participating Providers FR 483.73.	E 0000	The creation and submission this Plan of Correction does a constitute an admission by the provider of any conclusion see in the statement of deficiencity of any violation of regulation. This provider respectfully required that the 2567 Plan of Correct be considered the Letter of Credible Allegation and required Desk Review in lieu of a Post Survey Revisit on or after 10/31/24.	not nis et forth es, or quests ion ests a		
Quality Review con	npleted on 10/09/24					
Licensure Survey w Department of Heal 483.90(a). Survey Date: 10/07 Facility Number: 0 Provider Number: AIM Number: 2010 At this Life Safety 0	ras conducted by the Indiana th in accordance with 42 CFR 7/24 12564 155788 018510 Code survey, Greenwood	K 0000	The creation and submission this Plan of Correction does a constitute an admission by the provider of any conclusion see in the statement of deficiencity of any violation of regulation. This provider respectfully required that the 2567 Plan of Correct be considered the Letter of Credible Allegation and required Desk Review in lieu of a Poss Survey Revisit on or after 10/31/24.	not nis et forth es, or nuests nion ests a		
	At this Emergency Preconducted by the In accordance with 42 Survey Date: 10/07 Facility Number: AIM Number: 2010 At this Emergency Preconducter and Mediand Suppliers, 42 C The facility has 169 the survey, the censure Survey we conducted by the In accordance with 42 Survey Date: 10/07 Facility Number: 0 Provider Number: 42 C The facility has 169 the survey, the censure Survey we conducted by the In accordance with 42 Survey Date: 10/07 Facility Number: 0 Provider Number: 0 Provider Number: 0 Provider Number: 2010 At this Life Safety Code Licensure Survey we conducted by the In accordance with 42 A Life Safety Code Licensure Survey we Department of Health 483.90(a).	ROVIDER OR SUPPLIER WOOD MEADOWS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/07/24 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Emergency Preparedness survey, Greenwood Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 169 certified beds. At the time of the survey, the census was 135. Quality Review completed on 10/09/24 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	ROVIDER OR SUPPLIER WOOD MEADOWS SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/07/24 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 169 certified beds. At the time of the survey, the census was 135. Quality Review completed on 10/09/24 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: 10/07/24 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Life Safety Code survey, Greenwood	ROVIDER OR SUPPLIER ### A BUILDING B. WING ### STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATTE ROAD 135 GREENWOOD, IN 46142 ### STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATTE ROAD 135 GREENWOOD, IN 46142 ### STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATTE ROAD 135 GREENWOOD, IN 46142 ### STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATTE ROAD 135 GREENWOOD, IN 46142 ### BUILDING ### STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATTE ROAD 135 GREENWOOD, IN 46142 ### BUILDING ### STATE ROAD 135 GREENWOOD, IN 46142 ### BUILDING ### PROVIDERS PLAN OF CORRECTION CO		

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

(X6) DATE

Laura Carter **Executive Director** 10/20/2024

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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TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS STATEMENT OF DEFICIENCIES AX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155788		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (x)	(X3) DATE SURVEY COMPLETED 10/07/2024	
		2	STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATE ROAD 135 GREENWOOD, IN 46142		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Life Safety from Fi National Fire Protect Life Safety Code (I Health Care Occupa- This one story facil Type V (111) const The facility has a fi detection in the cor- the corridor. The fa hardwired to the fir resident sleeping ro capacity of 169 and time of this visit. All areas where res- were sprinklered an services were sprinklered and Services were sprinklered and Quality Review cor-	ity was determined to be of ruction and fully sprinklered. re alarm system with smoke ridors and in all areas open to acility has a land a census of 135 at the lidents have customary access dall areas providing facility			
K 0232 SS=E Bldg. 01	failed to meet the corridors or met an 19.2.3.4(5) states w	Ramp Width on and interview, the facility lear width requirement for 1 of 7 exception per 19.2.3.4(5). LSC there the corridor width is at tions into the required width	K 0232	K232 (E) Aisle, Corridor or Ram Width What corrective action(s) will be accomplished for those residents found to have been	p 10/30/2024
	all of the following (a) the fixed furnitu floor or to the wall. (b) the fixed furnitu unobstructed corrid except as permitted	are is securely attached to the are does not reduce the clear or width to less than six feet,		affected by the deficient practice? The Maintenance Director/designee moved the ch from one side of the hallway to t other on 10/14/24. All furniture located on one side of the hallway. All furniture is affixed to the	he is

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of the corridor.

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wall.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155788			ILDING	ONSTRUCTION 01	(X3) DATE COMPL 10/07/	ETED	
NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS			•	1200 N	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135 IWOOD, IN 46142		
(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)	TE	(X5) COMPLETION DATE
	(d) the fixed furnitu grouping does not efeet. (e) the fixed furnitu 19.2.3.4(5) (d) are so distance of at least 1 (f) the fixed furnitur obstruct access to be protection equipment (g) corridors through are protected by an automatic smoke dowith 19.3.4, or the farranged and locate by the facility staff space. (h) the smoke compethroughout by an apprinkler system in This deficient practice residents, staff and Findings include: Based on observation Director during the facility from 9:15 and furniture was stored up against the corridor and the Fieduring a tour of the p.m. on 10/07/24, the corridor outside and 123. The sofa coutside Room 123 vand restricted the clevidth to six feet. B	re is grouped such that each xceed an area of 50 square re groupings addressed in eparated from each other by a 10 feet. re is located so as to not wilding service and fire nt. thout the smoke compartment electrically supervised tection system in accordance fixed furniture spaces are d to allow direct supervision from a nurse's station or similar artment is protected approved, supervised automatic accordance with 19.3.5.8 fee could affect over 20 visitors. The system is a conditional accordance with 19.3.5.8 fee could affect over 20 visitors. The system is a conditional accordance with 19.3.5.8 fee could affect over 20 visitors. The system is a conditional accordance with 19.3.5.8 fee could affect over 20 visitors.	C4LG21		How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked. All residents residing on 10 hall have the potential to be affected by this deficient praction. The furniture was moved to side of the 100 hallway and aft to the wall by the Maintenance Director/designee 10/14/24. All halls were observed by Maintenance Director/designee nesure no furniture corridors a unobstructed with 6 feet width. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The furniture was moved to side of the hall and affixed to side of the hall and affixed to side of the Maintenance Director/designee 10/14/24. Maintenance Director/desig will complete the POC daily rounding tool to ensure corridor are unobstructed. How the corrective action (side) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? The Life Safety POC QAPI will be utilized by Maintenance.	en? o one fixed e e to are o one the ut Tool	ge 3 of 16

		X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155788	B. WING 10/07/2024			2024	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135		
GREENWOOD MEADOWS				NWOOD, IN 46142			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nce Supervisor agreed furniture			Director/designee weekly x 4		
		sides of the corridor in the 100			weeks, monthly x 6 months, a		
	Hall.				quarterly thereafter for one year		
	יים ניים ניים ניים ניים ניים ניים ניים	. 1 4 . 4			with results reported to the Qu	iality	
	These findings were	or and the Field Maintenance			Assurance and Performance		
					Improvement Committee over	seen	
	Supervisor during the	ne exit conference.			by the Executive Director If a threshold of 95% is not		
	3.1-19(b)				achieved, an action plan will b		
	3.1-19(0)				developed to ensure complian		
					developed to ensure compliant	ce.	
K 0291	NFPA 101						
SS=F	Emergency Lightir	ng					
Bldg. 01	3 , 3	3					
	Based on observation	on and interview, the facility	K 0	291	K 291 (F) Emergency Lighting		10/30/2024
	failed to ensure 1 of	f 1 battery powered emergency			What corrective action(s) wil		
	lighting systems wa	s maintained in accordance			be accomplished for those		
	with LSC Section 7	.9. LSC 7.9.2.6 states battery			residents found to have beer	1	
	operated emergency	lights shall use only reliable			affected by the deficient		
		le batteries provided with			practice?		
		r maintaining them in properly			·IEI was contacted for service		
	-	Batteries used in such lights			IEI diagnosed battery issue or	1	
		proved for their intended use			10/15/24. The battery was		
		ith NFPA 70, National Electric			ordered and will be replaced b	y IEI	
		nt practice could affect all			once received.		
	residents, staff and	visitors.					
	Findings include:				How will you identify other	_	
	Findings include:				residents having the potentia	31	
	Rased on observation	ons with the Maintenance			to be affected by the same deficient practice and what		
		eld Maintenance Supervisor			corrective action will be take	n2	
		facility from 1:00 p.m. to 2:50			·All residents have the poter		
	-	ne battery operated lighting			to be affected by this deficient		
	-	ide the weatherproof shell for			practice.		
	-	erator located outside the			·The Maintenance		
		hwest side of the property			Director/designee will check the	ne	
	_	when its respective power plug			battery-operated emergency		
		the electrical outlet inside the			lighting system on the general	or	
		multiple times. Based on			weekly.		
	_	e of the observations, the			What measures will be put in	ito	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01		COMPLETED		
		155788	B. WING 10/07/2024			/2024	
				_	_		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					STATE ROAD 135		
GREENV	WOOD MEADOWS			GREEN	IWOOD, IN 46142		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DE OVERENCE N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
		tor stated the battery powered			place or what systemic		
		system does not have a test			changes you will make to		
		nonthly by unplugging its			ensure that the deficient		
		reed the battery light failed to			practice does not recur.		
	illuminate when tes				·The Maintenance Director v	vill	
					check the battery-operated	••••	
	These findings wer	e reviewed with the			emergency lighting system on	the	
		tor and the Field Maintenance			generator weekly.		
	Supervisor during t				·The Maintenance		
					Director/designee will complet	e	
	3.1-19(b))				the Preventative Maintenance		
	, , , , , ,				for the generator's emergency		
					lighting every month.		
					·The Executive		
					Director/designee will review t	he	
					TELS completion monthly for		
					compliance.		
					Somphanes.		
					How the corrective action (s))	
					will be monitored to ensure t		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place?		
					· The Life Safety POC QAPI	Tool	
					will be utilized by Maintenance		
					Director/designee weekly x 4		
					weeks, monthly x 6 months, a	nd	
					quarterly thereafter for one ye		
					with results reported to the Qu		
					Assurance and Performance	-	
					Improvement Committee over	seen	
					by the Executive Director		
					·If a threshold of 95% is not		
					achieved, an action plan will b	е	
					developed to ensure complian		
					,		
K 0353	NFPA 101						
SS=F		- Maintenance and Testing					

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Bldg. 01

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/07/2024 155788 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1200 N STATE ROAD 135 **GREENWOOD MEADOWS** GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on record review, observation and K 0353 10/30/2024 K 353 (F) interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. **Sprinkler** NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection System/Mainte Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be nance and inspected monthly to ensure that they are in good condition and that normal water supply pressure **Testing** is being maintained. Section 5.1.2 states valves and fire department connections shall be What corrective action(s) will inspected, tested, and maintained in accordance be accomplished for those with Chapter 13. Section 13.3.2.1 states that all residents found to have been valves shall be inspected weekly. Section 4.3.1 affected by the deficient states records shall be made for all inspections, practice? tests, and maintenance of the system and its The Maintenance components and shall be made available to the Director/designee checked the wet authority having jurisdiction upon request. This sprinkler system on 10/14/24 and deficient practice could affect all residents and completed documentation. staff in the facility. How will you identify other residents having the potential Findings include: to be affected by the same deficient practice and what Based on record review with the Director of corrective action will be taken? Property Management, the Maintenance Director All residents have the and the Field Maintenance Supervisor from 9:25 potential to be affected by the a.m. to 12:45 a.m. on 10/07/24, monthly wet alleged deficient practice. sprinkler gauge inspection documentation for the A monthly Preventative most recent twelve month period was not Maintenance task was added to available for review. Based on interview at the the TELS program to test the wet time of record review, the Maintenance Director sprinkler system every month. stated the facility has both wet and dry sprinkler What measures will be put into systems and agreed monthly wet sprinkler gauge place or what systemic inspection documentation for the most recent changes you will make to twelve month period was not available for review. ensure that the deficient Based on observations with the Maintenance practice does not recur? Director and the Field Maintenance Supervisor A monthly Preventative during a tour of the facility from 1:00 p.m. to 2:50 Maintenance task was added to p.m. on 10/07/24, the facility has two wet sprinkler the TELS program to test the wet systems and two dry sprinkler systems.

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sprinkler system every month.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155788		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/07/2024	
	PROVIDER OR SUPPLIER		1200 N	ADDRESS, CITY, STATE, ZIP COD I STATE ROAD 135 NWOOD, IN 46142	
(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
	These findings were Maintenance Direct Supervisor during the 3.1-19(b)	or and the Field Maintenance		The Maintenance Director/designee will complete the wet sprinkler system testir monthly and document complete in the TELS system. The Executive Director/designee will review completion monthly for compliance. How the corrective action (somit will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? The Life Safety POC QAFT Tool will be utilized weekly a weeks, monthly a months, a quarterly thereafter for one yee with results reported to the Quantum Assurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant.	ng etion TELS) the ut Pl ind ar uality seen
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extir				
	failed to ensure 1 of	on and interview, the facility 23 portable fire extinguishers nce at periods not more than	K 0355	K 355 (D)	10/30/2024
	one year apart. NF	PA 10, the Standard for guishers, at Section 7.3.1.1.1		Portable Fire	
	requires that fire ex to maintenance at ir year, at the time of specifically indicate	tinguishers shall be subjected attervals of not more than 1 hydrostatic test, or when bed by an inspection or on. Section 3.3.15 defines		Extinguishers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	II

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155788		A. BUILDING B. WING	01	COMPLETED 10/07/2024
	PROVIDER OR SUPPLIER		1200 N	ADDRESS, CITY, STATE, ZIP COD I STATE ROAD 135 NWOOD, IN 46142	
(X4) ID PREFIX TAG	LEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
IAU	extinguisher mainted examination of the intended to give made extinguisher will operand to determine if will prevent its open replacement is necestesting or internal material	nance as a thorough fire extinguisher that is ximum assurance that a fire berate effectively and safely physical damage or condition ration, if any repair or ssary, and if hydrostatic naintenance is required. each fire extinguisher shall becurely attached that and year the maintenance was to the person performing the to the name of the agency to the name	IAG	practice? Whitlock completed the annual test on 3/18/2024 for extinguisher in question. Wh was contacted and provided tag on 10/15/24. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken all residents have the potential to be affected by the alleged deficient practice. The Maintenance Director/designee will check extinguishers for updated tagen annual testing. The Maintenance Director/designee will contact testing company if new tags needed. What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance Director/designee will edit the Preventative Maintenance at task in TELS to include check the extinguishers for new tagen annually. The Maintenance Director/designee will ensure annual testing for extinguish completed and documented tag and in the TELS Prevent Maintenance system.	the itlock a new tial ten? e all fire gs and ance of the are into e nnual cking gs e ers is on the

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155788		A. BUILDING B. WING	01	COMPLETED 10/07/2024	
	PROVIDER OR SUPPLIER		1200 N	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 135 NWOOD, IN 46142	
(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
				The Executive Director wi review the TELS Preventative Maintenance documentation monthly for compliance.	11
				How the corrective action (s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be printo place? The Life Safety POC QAFT Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quarterly the second Performance Improvement Committee oversely the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant.	ut Pl Ind ar iality seen ot e
K 0522 SS=D Bldg. 01	NFPA 101 HVAC - Any Heati	ng Device			
	failed to ensure 1 of		K 0522	K522 (D)	10/30/2024
	from the outside for	led with intake combustion air rooms containing fuel fired ficient practice could create an		HVAC/Any	
	atmosphere rich wit could cause physica vicinity of the room	h carbon monoxide which Il problems for all staff in the This deficient practice could f visitors in the Laundry.		Heating Devic What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? CH Mechanical was	ı
		ons with the Maintenance eld Maintenance Supervisor		contacted by the Maintenance Director/designee to synchron	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155788		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/07/2024	
NAME OF PROVIDER OR SUPPLIER GREENWOOD MEADOWS			1200 N	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135 NWOOD, IN 46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION facility from 1:00 p.m. to 2:50	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) the Louvre systems to open v	DATE
	p.m. on 10/07/24, t powered Louvre sy outside wall behind the dryer room area dryers with intake a two by fours were a both Louvre systen to allow the dryers air. When the two slats closed and did the dryers were turn the time of the obse Director stated new week, the electrical not synchronized to and agreed it could	wo wall mounted electrically stems were installed in an a the natural gas fired dryers in a of the Laundry to provide the air from the outside. Wooden inserted in between slats for inserted in between slats for inserted to be provided with make-up by fours were removed, the anot open electrically when ined on. Based on interview at ervations, the Maintenance of dryers were installed last ly powered Louvre systems are to open with dryer activation into be assured the natural gas be continually provided with		dryer activation on 10/14/24. How will you identify other residents having the potentit to be affected by the same deficient practice and what corrective action will be take. All residents have the potential to be affected by the alleged deficient practice. CH Mechanical was contacted by the Maintenance Director/designee to synchror the Louvre systems to open with dryer activation on 10/14/24. The Maintenance Director/designee will add a monthly task in the Preventat	en?
	These findings wer	en directly from the outside. e reviewed with the tor and the Field Maintenance he exit conference.		Maintenance TELS system to check function of the Louvre systems. The Laundry staff will be educated by the Maintenance Director/designee to observe Louvre system, and to contact Maintenance immediately if concerns are identified. What measures will be put in place or what systemic	the tt
				changes you will make to ensure that the deficient practice does not recur? The Maintenance Director/designee will add a monthly task in the Preventat Maintenance TELS system to check function of the Louvre systems. The Maintenance	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155788	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 10/07/2024
	PROVIDER OR SUPPLIE		1200 N	ADDRESS, CITY, STATE, ZIP COD N STATE ROAD 135 NWOOD, IN 46142	
(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)	(X5) COMPLETION DATE
				Director/designee will check to function of the Louvre system monthly and document complete in TELS Preventative Maintensystem. The Executive Director work review the TELS Preventative Maintenance system monthly documentation completion. The Laundry staff will be educated by the Maintenance Director/designee to observe Louvre system, and to contact Maintenance immediately if concerns are identified. How the corrective action (swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be pinto place? The Life Safety POC QAI Tool will be utilized weekly xeleves, monthly x 6 months, a quarterly thereafter for one year with results reported to the Quasturance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is machieved, an action plan will be developed to ensure compliant.	s etion nance lill s for sthe t lill s for sthe t lill s for state t lill s for s for state t lill s for state t lill s for state t lill s for s for state t lill s for state t lill s for state t lill s for s for state t lill s for state t li
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Dec				
	failed to ensure 2 of	on and interview, the facility of over 50 corridor doors were	K 0753	K753 (E)	10/30/2024
		rdance with 19.7.5.6. 19.7.5.6 decorations shall be prohibited		Combustible	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155788		(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 10/07/2024		
		PROVIDER OR SUPPLIER		1200	r address, city, state, zip cod N STATE ROAD 135 ENWOOD, IN 46142	
	(X4) ID PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	TAG	in any health care o	ccupancy, unless one of the	TAG	<u>†_</u>	DATE
		following criteria is (1) They are flame- approved fire-retard labeled for applicat applied. (2) The decorations NFPA 701, Standar Flame Propagation (3) The decorations exceeding 100 kW NFPA 289, Standar Individual Fuel Pac ignition source. (4)*The decorations paintings, and other the walls, ceiling, a accordance with the (a) Decorations on a interfere with the op latching of the door limitations of 19.7 (b) Decorations do wall, ceiling, and de space of a smoke co protected throughor sprinkler system in (c) Decorations do wall, ceiling, and de space of a smoke co	met: retardant or are treated with lant coating that is listed and ion to the material to which it is meet the requirements of d Methods of Fire Tests for of Textiles and Films. exhibit a heat release rate not when tested in accordance with d Method of Fire Test for kages, using the 20 kW s, such as photographs, art, are attached directly to and non-fire-rated doors in e following: non-fire-rated doors do not peration or any required and do not exceed the area		What corrective action(s) wishe accomplished for those residents found to have been affected by the deficient practice? The paper sheets were reformed the doors of the Staff Development office and There Gym immediately on 10/7/202 the Maintenance Director/designee. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be taken all residents residing in the facility have the potential to be affected by this deficient practice and what corrective action will be taken affected by this deficient practice and what corrective action will be taken as a significant practice and what corrective action will be taken and the potential to be affected by this deficient practice. The Department Managers be educated on the hanging of signs by the Executive Director/designee. Maintenance Director/ designed the facility to ensure other untreated paper decorate were placed on door.	en moved rapy 24 by ial en? e e e tice. s will of ignee no
		(d) Decorations do wall, ceiling, and do sleeping rooms hav	accordance with Section 9.7. not exceed 50 percent of the oor areas inside patient ing a capacity not exceeding		What measures will be put i place or what systemic changes you will make to ensure that the deficient	nto
		protected throughou automatic sprinkler Section 9.7.	noke compartment that is at by an approved, supervised system in accordance with ations, such as photographs		practice does not recur? The Department Manage will be educated on the hangi signs by the Executive Director/designee.	

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EPARTMENT OF HEALTH AND HUMAN SERVICES						
ENTERS FOR MEDICARE & MEDICA	& MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING <u>01</u>	COMPLETED		
	155788	B. WI	NG	10/07/2024		
			STREET ADDRESS, CITY, STATE, ZIP COD			

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1200 N STATE ROAD 135				
GREEN	WOOD MEADOWS	GREE	NWOOD, IN 46142				
(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			
	and paintings, in such limited quantities that a hazard of fire development or spread is not present. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Field Maintenance Supervisor during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 10/07/24, paper sheets measuring 8.5 inches by eleven inches were affixed to the corridor side of the corridor door to the Staff Development Office in the 200 Hall. The paper sheets covered approximately 40 to 50 percent of the face of the corridor door. In addition, paper signage and artwork were affixed to the corridor side of the corridor door the Therapy Gym from the 400 Hall. The paper signage and artwork covered approximately 50 percent of the face of the corridor door. Based on interview at the time of the observations, the Maintenance Director stated the paper sheets, signage and artwork were not treated with fire retardant material and agreed that the affixed items exceeded 30 percent of the face of the corridor doors. These findings were not reviewed with the Maintenance Director and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		The ED/designee will meet with Resident Council President/Council to review the hanging paper on doors. The Maintenance Director/designee will round the facility using a POC rounding tool to ensure paper decorations are not hung on doors. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance				
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors						
	Based on record review, observation and interview; the facility failed to ensure the proper operation was maintained for 1 of 1 rolling steel	K 0761	K761 (E)	10/30/2024			

						PRIN	TED:	10/25/2024	
EPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED		
ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 09	938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION (X3) DA				ΓΕ SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED			
		155788	B. WI	NG		10/07/	2024		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD						
			1200 N STATE ROAD 135						
GREENV	GREENWOOD MEADOWS GREENWOOD, IN 46142								
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	ID		(X5)		X5)	
` /				PROVIDER'S PLAN OF CORRECTION			`	LETION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		CROSS-REFERENCED TO THE APPROPRIA	ATE	COMP	LETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)			ATE	
	fire door was in acc	ordance with NFPA 80. LSC			Maintanana				

4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states that after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room.

Findings include:

Based on review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 04/28/23 with the Director of Property Management, the Maintenance Director and the Field Maintenance Supervisor from 9:25 a.m. to 12:45 a.m. on 10/07/24, "NA" was listed as the results of "Drop Test 1" and "Drop Test 2". Review of the rolling fire door inspection contractor's "Fire Door Drop Test" documentation dated 03/25/24 indicated "Drop Test 1" and "Drop Test 2" passed testing. Based on interviews at the time of record review, the Director of Property Management and the Maintenance Director stated the rolling fire door is not connected to the fire alarm system, it is not self-closing or automatic closing and only closes by manually pulling the

Maintenance Inspection & **Testing/Doors**

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

·IEI and Overhead Door were contacted on 10/17/24 by the Maintenance Director/designee to install an automatic closing device to the rolling steel door located between the kitchen and Main Dining room.

The rolling steel door will be added to the current fire system.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

·All residents residing in the facility have the potential to be affected by the deficient practice.

·IEI and Overhead Door were contacted on 10/17/24 by the Maintenance Director/designee to install an automatic closing device to the rolling steel door located between the kitchen and Main Dining room.

The rolling steel door will be added to the current fire system.

·The Maintenance Director/designee will test the

C4LG21

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CENTERS FOR MEDICARE & MEDICAID SERVICES 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 COMPLETED 01 B. WING 10/07/2024 155788 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1200 N STATE ROAD 135 **GREENWOOD MEADOWS** GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE door down. Based on observations with the system monthly and document Maintenance Director and the Field Maintenance completion in the Preventative Supervisor during a tour of the facility from 1:00 Maintenance TELS system. p.m. to 2:50 p.m. on 10/07/24, the metal rolling fire ·Whitlock will complete annual door between the kitchen and main Dining Room testing. The completed testing was not equipped with a fusible link and was not will be documented annually in the self-closing or automatic closing. Preventative Maintenance TELS system. These findings were reviewed with the Maintenance Director and the Field Maintenance What measures will be put into Supervisor during the exit conference. place or what systemic changes you will make to 3.1-19(b)ensure that the deficient practice does not recur? ·The Maintenance Director/designee will test the system monthly and document completion in the Preventative Maintenance TELS system. ·Whitlock will complete annual testing. The completed testing will be documented annually in the Preventative Maintenance TELS system. ·The Executive Director/designee will review the Preventative Maintenance TELS system monthly for completion of documentation. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

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The Life Safety POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155788	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SUI COMPLETI 10/07/20	ED
	PROVIDER OR SUPPLIEF		1200 N	ADDRESS, CITY, STATE, ZIP COD STATE ROAD 135 IWOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) OMPLETION DATE
				with results reported to the Qua Assurance and Performance Improvement Committee overs by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	eeen t	

Event ID: C4LG21 Facility ID: 012564 Page 16 of 16 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet