STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155788	A. BUILDING -- B. WING	10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 GREENWOOD, 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/02/23 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Emergency Preparedness survey, Greenwood Meadows was found in substantial 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 140. Quality Review completed on 10/06/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit December on or after October 31, 2023.	
E 0041 SS=C Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Dyer	Executive Director	10/26/2023

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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	(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by			

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October			

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	22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test Generator Under Load" documentation for the most recent twelve month period with the Executive Director and the Regional Field Maintenance Supervisor during record review from 9:00 a.m. to 12:25 p.m. on 10/02/23, it had been greater than 40 days in between monthly load testing conducted on 05/10/23 and on 07/01/23. Review of documentation for an emergency preparedness actual loss of building power event due to wind from a thunderstorm on 06/29/23 and review of an after action report for the occurrence indicated the building power was transferred to the emergency generator running under load starting on 06/29/23 for a 48 hour period through 6:00 p.m. on 07/01/23. Based on interview at the time of record review, the Regional Field Maintenance Supervisor stated the facility has one diesel fired emergency generator and agreed it had been greater than 40 days in between monthly load testing for the period of	E 0041	p="" paraid="1481745376" paraeid="{e5a86728-8b2a-4381-a34b-f79f64c2b72e}{203}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director will record the load tested on the generator within 40 days of the last test. The Maintenance Director completed the generator load test 10/16/23. 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 have the potential to be affected by this deficient practice. ul="" role="list" The Maintenance Director will be educated on the timing of the generator testing. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The Maintenance Director will be educated on the timing of the generator testing. The Maintenance Director will record the percentage of load tested on	10/31/2023

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	05/10/23 to 07/01/23. Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 275 kW and was manufactured 06/04/15. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference.		the Generator monthly in the TELS system every 40 days. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ul="" role="list" The Life Safety POC QAPI Tool will be utilized by Maintenance Director/designee 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 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: 10/02/23 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Life Safety Code survey, Greenwood Meadows 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,	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit December on or after October 31, 2023.	

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	Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hardwired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 169 and had a census of 140 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 10/06/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 corridor door sets in the 500 Hall would self close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the 500 Hall Lounge. Findings include:	K 0100	p="" paraid="179183364" paraeid="{c0916e74-f914-4390-a570-0426fbba0c01}{72}">What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ADA was contacted and came in and adjusted the corridor door set in 500 on 10/3/23. p="" paraid="2014992464"	10/31/2023

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	Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, the north door in the corridor door set to the 500 Hall Lounge was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation, latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Regional Field Maintenance Supervisor agreed the north door in the corridor door set to the 500 Hall Lounge would not fully self close and latch into the door frame. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference. 3.1-19(b)		paraeid="{c0916e74-f914-4390-a570-0426fbba0c01}{91}">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 on the 500 have the potential to be affected by this deficient practice. The Maintenance Director and ADA reviewed all corridor doors for compliance on 10/3/23. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur. The Maintenance Director will check corridor doors during monthly fire drills to properly. p="" paraid="1717176063" paraeid="{c0916e74-f914-4390-a570-0426fbba0c01}{140}">How 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 by Maintenance Director/designee 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	

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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 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			

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	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 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 the means of egress through 2 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include:	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Maintenance Director changed the exit door code in the 400 Hall Dining room to match the posting. The exit hall door code for the 500 hall exit was re-posted. **How will you identify other residents having the potential to be affected by the same deficient practice and what**	10/31/2023

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	Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, the exit door to the outside of the facility in the 400 Hall Dining Room and the exit door to the outside of the facility near Room 520 in the 500 Hall were each marked as a facility exit with an exit sign. Each door could be opened by entering a four digit code into a keypad at the exit door set but the posted code at the 400 Hall Dining Room exit would not release the door to open. The Regional Field Maintenance Supervisor tried entering different codes to release the door to open but the door still would not release to open. In addition, the code to release the 500 Hall exit door to open was not posted at the keypad at the exit door by Room 520. The Regional Field Maintenance Supervisor entered the code that should have been posted and the exit door released to open. Based on interview at the time of the observations, the Regional Field Maintenance Supervisor agreed the 400 Hall Dining Room exit door would not release to open and the code to release the 500 Hall exit door to open was not posted at the keypad at the exit door. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference. 3.1-19(b)		**corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice All exit doors with codes were checked by the Maintenance Director to ensure codes were applicable. Exit Door Codes to be updated monthly by the Maintenance Director. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director/designee will update Exit door codes and posted codes for all exit doors by the first business day of the month. **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 =”” p=””> If a threshold of 95% is not achieved, an action plan will be	

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			developed to ensure compliance =”” p=””>	
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 3 of over 18 hazardous areas such	K 0321	**What corrective action(s) will be accomplished for those**	10/31/2023

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	as laundries (larger than 100 square feet), fuel fired heater rooms and combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, the following was noted: a. the top of the door frame was separated from the door frame on the latching side of the corridor door to the clean side of the laundry room in the service hall. As a result, the corridor door to the room would not latch into the door frame. The laundry measured greater than 100 square feet. b. the annular space surrounding one of two PVC pipes which penetrated the ceiling of the natural gas fired furnace room inside the 500 Hall Laundry Services Room was not firestopped. c. the corridor door to the former employee breakroom by the restroom in the service hall was not equipped with a self closing device. The former breakroom measured twelve feet by twenty-five feet and was now used as a storage room for combustible supplies and boxes. Based on interview at the time of the observations, the Regional Field Maintenance Supervisor agreed the aforementioned three hazardous areas were not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit		**residents found to have been affected by the deficient practice?** The door frame to the clean side of the laundry room was repaired by the Maintenance Director. The PVC pipe that penetrates the ceiling of the nautrual gas fired furnace room inside the 500 Hall Laundry Services Room was firestopped by the Maintenance Director. A self-closing devices hinge was added to the storage room by the Maintenance Director. **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 have the potential to be affected by the alleged deficient practice Maintenance Director/designee to make rounds and review door frames, all storage areas for self-closing devices/spring-loaded hinges and ensure pipes are firestopped. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Maintenance Director/designee to make rounds and review door frames, all storage areas for self-closing devices/spring loaded hinges and	

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	conference. 3.1-19(b)		ensure pipes are firestopped. **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?** 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 ="" p=""> ="" p=""> ="" p=""> ="" p="">	
K 0353 SS=E 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, 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			

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	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 1 refreshment pantry storage rooms in the 200 Hall. 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 10 residents, staff, and visitors in the vicinity of the refreshment pantry storage room by the Salon in the 200 Hall. Findings include: Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, three suspended ceiling tiles were missing in the ceiling in the refreshment pantry storage room by the Salon in the 200 Hall. Based on interview at the time of the observations, the Regional Field Maintenance Supervisor agreed the missing ceiling tiles would delay activation of the sprinkler located in the room. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference.	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The 3 missing ceiling tiles were replaced by the Maintenance Director. **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 have the potential to be affected by the alleged deficient practice Maintenance Director/designee to make rounds and ensure ceiling tiles are in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director/designee to include storage rooms when making rounds and ensure ceiling tiles are in place. **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**	10/31/2023

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	3.1-19(b)		**into place?** 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 ="" p=""> ="" p=""> ="" p="">	
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			

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	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 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 2 of over 75 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, the corridor door to resident sleeping Room 401 and Room 520 each failed to latch into the door frame when tested to close multiple times. The latching mechanism for each corridor door failed to protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Regional Field Maintenance Supervisor agreed the aforementioned two	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·ADA was contacted and came in and adjusted the corridor door set in 400 and 500 hall on 10/3/23. **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 on the 400 and 500 hall have the potential to be affected by this deficient practice. ·The Maintenance Director and ADA reviewed all corridor doors for	10/31/2023

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	corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference. 3.1-19(b)		compliance on 10/3/23. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director will check corridor doors during monthly fire drills to ensure they are functioning properly. **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?** 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 ="" p="">"> If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes.			

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	Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on record review, observation and interview; the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 50 residents, staff and visitors in the vicinity of the corridor smoke barrier door set by Room 304 in the 300 Hall. Findings include: Based on review of facility blueprint documentation with the Executive Director and the Regional Field Maintenance Supervisor during record review from 9:00 a.m. to 12:25 p.m. on 10/02/23, two hour fire resistance rated fire walls are constructed in each of the five halls near Room 104, Room 202, Room 304, Room 402 and Room 508. Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, each door in the corridor door set in the two hour fire resistance rated fire wall by Room 304 in the 300 Hall was held in the fully open position with a wall mounted magnetic holding	K 0374	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·ADA was contacted and came in and evaluated the corridor door set in 300 hall on 10/3/23. ·The Maintenance Director placed hinge shims made for the door set on 300 hall. **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 on the 300 hall have the potential to be affected by this deficient practice. ·The Maintenance Director and ADA reviewed all corridor doors for compliance on 10/3/23. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The Maintenance Director will check corridor doors during	10/31/2023

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	device set to release with fire alarm activation. Each door was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door and each door was equipped with latching hardware to latch the door into the door frame. The north door in the corridor door set failed to fully self close because the bottom of the door became stuck on the floor when tested to close multiple times. Based on interview at the time of the observations, the Regional Field Maintenance Supervisor stated the door frame for the north door became separated from the wall it had been mounted up against which caused the door to drag on the floor and become stuck on the floor when tested to close. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference. 3.1-19(b)		monthly fire drills to ensure they are functioning properly. **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?** 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 ="" p="">"> If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected	K 0712	**What corrective action(s) will be accomplished for those**	10/31/2023

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	times under varying conditions on the third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" and "Fire Drill Report Form" documentation with the Executive Director and the Regional Field Maintenance Supervisor during record review from 9:00 a.m. to 12:25 p.m. on 10/02/23, ten of twelve third shift fire drills conducted within the most recent twelve month period were conducted in the 5:00 a.m. hour of the day. The ten fire drills were conducted on the following dates and times: a. 12/06/22 at 5:30 a.m. b. 01/27/23 at 5:00 a.m. c. 02/28/23 at 5:10 a.m. d. 03/30/23 at 5:15 a.m. e. 04/26/23 at 5:15 a.m. f. 05/17/23 at 5:10 a.m. g. 06/13/23 at 5:20 a.m. h. 07/28/23 at 4:55 a.m. i. 08/28/23 at 5:10 a.m. j. 09/08/23 at 5:15 a.m. Based on interview at the time of record review, the Regional Field Maintenance Supervisor stated the facility operates three shifts per day, it is company policy to conduct a fire drill once per month per shift and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference. 3.1-19(b) and 3.1-51(c)		**residents found to have been affected by the deficient practice?** Education provided to Maintenance Director regarding fire drills and scheduling. October night fire drill to be staggered from month previous. **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 have the potential to be affected by the alleged deficient practice Fire drills to be scheduled and completed on unexpected days and times under varying conditions. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Education provided to Maintenance Director regarding fire drills and scheduling. Fire drills to be scheduled throughout the month and completed on unexpected days and varying times. **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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			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 ="" p="">="" p="">="" p="">	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder			

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	circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document emergency generator monthly load testing for 1 month of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all	K 0918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director will record the load tested on the generator within 40 days of the last test. The Maintenance Director completed the generator load test 10/16/23. 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 have the potential to be affected by this deficient practice. The Maintenance Director will be educated on the timing of the generator testing. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? The Maintenance Director will be educated on the timing of the generator testing. The Maintenance Director will record	10/31/2023

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	residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Test Generator Under Load" documentation for the most recent twelve month period with the Executive Director and the Regional Field Maintenance Supervisor during record review from 9:00 a.m. to 12:25 p.m. on 10/02/23, it had been greater than 40 days in between monthly load testing conducted on 05/10/23 and on 07/01/23. Review of documentation for an emergency preparedness actual loss of building power event due to wind from a thunderstorm on 06/29/23 and review of an after action report for the occurrence indicated the building power was transferred to the emergency generator running under load starting on 06/29/23 for a 48 hour period through 6:00 p.m. on 07/01/23. Based on interview at the time of record review, the Regional Field Maintenance Supervisor stated the facility has one diesel fired emergency generator and agreed it had been greater than 40 days in between monthly load testing for the period of 05/10/23 to 07/01/23. Based on observations with the Regional Field Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:25 p.m. on 10/02/23, the diesel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 275 kW and was manufactured 06/04/15. These findings were reviewed with the Executive Director, the Director of Nursing and the Regional Field Maintenance Supervisor during the exit conference. 3.1-19(b)		the percentage of load tested on the Generator monthly in the TELS system every 40 days. How 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 by Maintenance Director/designee 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.	

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	155788	A. BUILDING 01 B. WING	10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 GREENWOOD, 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