STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING -- B. WING	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/04/21 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Emergency Preparedness survey, Greenwood Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 121 certified beds. At the time of the survey, the census was 73. Quality Review completed on 05/07/21	E 0000	May 18, 2021 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: M9S321 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on May 4, 2021. This letter is to inform you that the plan of correction attached is to serve as Greenwood Health & Living Community credible allegation of compliance. We allege substantial compliance on June 11, 2021. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-796-9776. Sincerely, Tina Le, HFA	

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

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			Administrator Greenwood Health and Living Submission of this plan of correction in no way constitutes an admission by Greenwood Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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).	K 0000	May 18, 2021 Brenda Buroker, Director	

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	Survey Date: 05/04/21 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Life Safety Code survey, Greenwood Health And Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility 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 battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 121 and had a census of 73 at the time of this visit. 52 of 67 resident sleeping rooms were surveyed. 15 resident sleeping rooms in the 500 Hall were not surveyed due to Covid-19 concerns. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 05/07/21		Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: M9S321 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on May 4, 2021. This letter is to inform you that the plan of correction attached is to serve as Greenwood Health & Living Community credible allegation of compliance. We allege substantial compliance on June 11, 2021. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-796-9776. Sincerely, Tina Le, HFA Administrator Greenwood Health and Living	

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			Submission of this plan of correction in no way constitutes an admission by Greenwood Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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 maintain latching hardware on 1 of 1 door sets to the north dining room per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features	K 0100	**K 100** **I. The corrective actions to be accomplished for those**	05/11/2021

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	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 north dining room. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, both doors in the door set serving as the entrance to the north dining room were "dogged down" which prevented the latching hardware at the top of the doors to latch each door into the door frame. The Maintenance Assistant was able to disable the "dogged down" status for the east door which was then able to latch into the door frame. The Maintenance Assistant was not able to not "dog down" the west door. As a result, the latching hardware for the west door did not latch the door into the door frame. Based on interview at the time of the observations, the Support Services & Life Safety Manager agreed the west door in the door set failed to latch into the door frame when tested to close multiple times. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice.** Observation - The entrance doors from the hallway to the north dining room would not latch. The panic hardware was not operable. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the north side of the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has adjusted the panic hardware to ensure proper operation. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director will audit this door system and all other door systems monthly to ensure proper operation. A TELS task is	

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			also set up to manage this task. See attached TELS task labeled "Door Inspection" **V. Plan of Correction completion date.** Plan of Completion date is May 11th, 2021.	
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			

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	automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS 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 1 of 8 delayed egress locks were readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed,	K 0222	**K 222** **I. The corrective actions to be accomplished for those residents found to have been**	05/11/2021

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	delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 20 residents, staff and visitors if needing to exit the		**affected by the deficient practice.** Observation - The exit door in the south dining room did not have the proper 15 second delayed egress posting on it. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the south side of the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has installed proper signage and tested the operation of the door system. See attached picture labeled “Egress Signage” showing the proper label. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director will audit this door system and all other exterior door systems weekly to	

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	facility from the south dining room. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, the exit door the outside of the facility in the south dining room was marked as a facility exit with an exit sign and was locked and was not equipped with signage indicating the door could be opened after pushing for 15 seconds. The exit door released to open after pushing for 15 seconds when tested to open. In addition, the door could also be opened by entering a four digit code, but the code was not posted. Based on interview at the time of the observations, the Support Services & Life Safety Manager agreed the aforementioned exit door in the south dining room was not equipped with the necessary signage indicating the door could be opened after pushing for 15 seconds. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		ensure proper operation and signage. An existing TELS task is in place to manage this. See attached TELS task labeled "Exterior Door Inspection" **V. Plan of Correction completion date.** Plan of Completion date is May 11th, 2021.	
K 0321 SS=F 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			

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	partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 8 hazardous areas such as boiler and fuel-fired heater rooms 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 all residents, staff, and visitors. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, a three foot by two foot hole was noted in the	K 0321	**K 321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – A recent boiler upgrade in the mechanical room left a large hole in the drywall ceiling. **II. The facility will identify other residents that may potentially be affected by the**	05/25/2021

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	ceiling of the boiler room and exposed the attic above. The hole was for the passage of fresh air intake piping and exhaust piping for the two natural gas fired boilers in the room. The boiler room is accessed from the outside of the facility by the service hall exit door. In addition, holes were noted in each of the three interior walls in the room near the floor which would not resist the passage of smoke. Based on interview at the time of the observations, the Support Services & Life Safety Manager stated new boilers were installed in the boiler room within the last two to three weeks, the work in the room is not yet completed but agreed the aforementioned openings would not resist the passage of smoke. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance Supervisor has contacted Dzul Drywall and Paint to come and repair this room. Pictures will be uploaded and emailed as soon as this project has been completed. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director will audit the boiler room monthly to ensure all penetrations are sealed up. **V. Plan of Correction completion date.** Plan of Completion date is May 25th, 2021.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING			

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	Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of over 10 storage rooms in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the comforter storage closet by the north nurse's station. Findings include:	K 0351	**K 351** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – Blankets and other items were stored too high in the north nurse station storage area. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice.	05/12/2021

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	Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, comforters were stored on the top shelf of the comforter storage closet by the north nurse's station within eight inches of the ceiling mounted sprinkler in the closet. Based on interview at the time of observations, the Support Services & Life Safety Manager agreed the comforter storage was within 18 inches below the sprinkler deflector. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Environmental Supervisor has reworked this storage area to ensure nothing is within 18” of the ceiling. See attached picture labeled “Storage Room” showing this room is compliant. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director will audit this room and all storage rooms monthly to ensure nothing is stored with 18” of the ceiling. **V. Plan of Correction completion date.** Plan of Completion date is May 12th, 2021.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.			

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(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
	Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 2 automatic sprinkler piping systems that were internally inspected as required by NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems in Chapter 14, Obstruction Prevention. Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. Section 14.3.1 states if the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the sprinkler system	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– During the last dry pipe sprinkler inspection the contractor documented that the attic dry pipe system needed to be flushed. Observation 2- There are 5 dry pipe sprinkler heads that are in harsh conditions that need to be tested or replaced. Observation 3- There was no FDC sign mounted to the exterior of the building. Observation 4- The was substances on 3 sprinkler heads that could impede the proper functionality of these heads.	06/11/2021

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	inspection contractor's letter dated 11/11/19 with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during record review from 9:00 a.m. to 12:55 p.m. on 05/04/21, the dry pipe sprinkler system for the facility needs to be flushed. The contractor's letter stated "Based off of the areas we inspected we recommend that a flush be performed on the mains, cross mains and lower upright lines" on the facility's dry pipe sprinkler system. Based on interview at the time of record review, the Support Services & Life Safety Manager stated the dry sprinkler system has not been flushed on or after 11/11/19. This finding was reviewed with the Administrator during the exit conference. 3-1.19(b) 2. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. Section 5.3.1.1.1.6 states dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. Section 5.3.1.1.1.6 states where sprinklers are subjected to harsh environments,		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- PIPE Incorporated has been contracted to perform a flush of the entire dry pipe system. See attached signed proposal for this flush. This is a tedious task and will take up to 3 weeks to complete. Observation 2- PIPE Incorporated has been contracted to replace the 5 sprinkler heads. They have measured these heads and have ordered. They will be replaced when the system is shut down to do the flush. Observation 3- Corporate has ordered FDC sign for facility which has not been delivered yet. Facility will install sign to the exterior of the building once obtained. Will update portal with	

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	including corrosive atmospheres and corrosive water supplies, on a 5-year basis, either sprinklers shall be replaced, or representative sprinkler samples shall be tested. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system contractor's "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" documentation dated 02/12/20 with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during record review from 9:00 a.m. to 12:55 p.m. on 05/04/21, dry pendant sprinklers located in harsh environments in the facility need to be replaced or a sample tested. The "Deficiency Summary" section of the report stated "walk-in freezer/cooler heads; exterior entryways are over 10 years old. There are (5) heads total (dry pendants)". Based on interview at the time of record review, the Support Services & Life Safety Manager stated he was uncertain of the status of dry sprinkler replacement or a sample tested on or after 02/12/20. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 fire department connections was in accordance with NFPA 25, 2011 Edition,		picture once installed. Observation 4- The Maintenance Supervisor has cleaned the debris from the sprinkler heads. See attached pictures labeled "Sprinkler Head" PIPE Inc. will replace painted sprinkler head while doing the internal inspection. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director will ensure that any type of recommendations from contractors is brought to the attention of the CarDon Corporate Facilities Director for immediate resolution. **V. Plan of Correction completion date.** Plan of Completion date is June 11th, 2021.	

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	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, identification signs were not provided for the fire department connection (FDC) located near the boiler room doors accessed from the outside of the building on the north side of the facility. Based on interview at the time of the observations, the Support Services & Life Safety Manager agreed an identification sign was not in place for the fire department connection (FDC). This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)			

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	4. Based on observation and interview, the facility failed to ensure 3 of over 200 sprinkler heads in the facility which had been painted or loaded with foreign materials were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the laundry. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, paint was noted on the deflector for the ceiling mounted sprinkler inside the Physician's Office near the corridor door. An unidentified green substance was noted on the deflector for the			

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	ceiling mounted sprinkler located behind the dryers in the laundry. A large amount of dust was noted on the deflector for the ceiling mounted sprinkler in front of the dryers in the laundry. Based on interview at the time of the observations, the Support Services & Life Safety Manager agreed the aforementioned sprinkler head locations had foreign materials on them or were painted. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 18 portable fire extinguishers were installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the laundry. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the	K 0355	**K355** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The fire extinguisher located on the laundry room was not properly mounted on the wall. Observation 2– The fire extinguisher located in the service hall has not been signed off on for the months of March and April.	05/07/2021

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	facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, the portable fire extinguisher located in the laundry was freestanding on a ledge six inches above the floor behind the washing machine by the entrance to the room from the corridor. The portable fire extinguisher had an affixed maintenance tag indicating the most recent annual maintenance was performed in February 2021 and the most recent monthly inspection was performed in April 2021. Based on interview at the time of the observations, the Support Services & Life Safety Manager agreed the portable fire extinguisher was not properly mounted. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 18 portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by these deficient practices. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1– The fire extinguisher located in the laundry room was mounted on the wall. See attached picture of mounted fire extinguisher. Observation 2– The fire extinguisher located in the service hall has been signed off on for the months of March, April, and now May. **IV The facility will monitor the corrective action by implementing the following measures.** A current TELS Task for this community is in place to inspect the fire extinguishers monthly. See attached Task labeled “Fire	

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	inspections have been performed. This deficient practice could affect over 2 staff in the service hall. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, the ABC type portable fire extinguisher located in the service hall by the exit door to the outside of the facility had an affixed maintenance tag lacking a monthly inspection for March and April 2021. The maintenance tag indicated the most recent annual inspection was conducted in February 2021. Based on interview at the time of the observations, the Support Services & Life Safety Manager agreed documentation of a March and April 2021 monthly inspection for the service hall portable fire extinguisher was not available for review. This finding was reviewed with the Administrator during the exit conference. 3-1.19(b)		Extinguisher Task" **V. Plan of Correction completion date.** Plan of Completion date is May 7th, 2021.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system			

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	is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, the following openings were noted in the ceiling smoke barrier: a. a three foot by two foot hole was noted in the ceiling of the boiler room and exposed the attic above. The hole was for the passage of fresh air intake piping and exhaust piping for the two natural gas fired boilers in the room. The boiler room is accessed from the outside of the facility near the exit door from the service hall on the north side of the facility.	K 0372	**K 372** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– A recent boiler upgrade in the mechanical room left a large hole in the drywall ceiling. Observation 2- There was a hole next to the low point drain in a public restroom on south that needed to be patched. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- Maintenance	05/25/2021

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	b. the annular space surrounding a one and one half inch in diameter low point drainpipe for the facility sprinkler system which penetrated the Patient Restroom ceiling was not firestopped. Based on interview at the time of the observations, the Support Services & Life Safety Manager stated new boilers were installed in the boiler room within the last two to three weeks, the work in the room is not yet completed but agreed the aforementioned openings in the ceiling smoke barrier were not protected to maintain the fire resistance rating of the ceiling smoke barrier. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Supervisor has contacted Dzul Drywall and Paint to come and repair this room. Pictures will be uploaded and emailed as soon as this project has been completed. Observation 2- Maintenance Supervisor has patched the hole around the pipe penetrating the ceiling. See attached picture labeled “low point patch” **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director will audit the entire building every 6 months to ensure all penetrations are sealed properly. See attached existing Task labeled “Fire Wall Penetrations” **V. Plan of Correction completion date.** Plan of Completion date is May 25th, 2021.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			

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	1. Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, one of two wall mounted electrical panels in the corridor by Room 407 and one of two wall mounted electrical panels in the corridor by the Spa across from Room 209 were each not locked. Based on interview at the time of the observations, the Support Services & Life Safety Manager agreed the aforementioned electrical panels in the corridor were not secured from non-authorized personnel. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0511	**K 511** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The electrical panels in the common area hallway across from resident room 209 were unlocked. Observation 2- There was an electrical junction box in the boiler room that did not have a cover plate on it. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- Maintenance Supervisor has locked the 2 electrical panels and has inspected all others for proper locking.	05/07/2021

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, the electrical junction box on the west wall of the boiler room which is accessed from the outside of the facility was without a cover which exposed the spliced electrical wiring in the junction box. Based on interview at the time of the observations, the Support Services & Life Safety Manager stated new boilers were installed in the boiler room within the last two to three weeks, the work in the room is not yet completed but agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Observation 2- Maintenance Supervisor has installed an electrical cover plate in the boiler room on an open junction box. See attached picture labeled "Junction Box" **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director will audit the entire building every 6 months to ensure all electrical panels are properly locked. See attached existing Task labeled "Electrical Panel Task" **V. Plan of Correction completion date.** Plan of Completion date is May 7th, 2021.	

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	155412	A. BUILDING 01 B. WING	05/04/2021

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GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to			

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	avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage and transfilling rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty. This deficient practice could affect over 5 residents, staff, and visitors in the vicinity of the oxygen storage and transfilling room near the south nurse's station. Findings include: Based on observations with the Administrator, the Support Services & Life Safety Manager, and the Maintenance Assistant during a tour of the facility from 1:15 p.m. to 2:55 p.m. on 05/04/21, four of four 'E' type oxygen cylinders were freestanding on the floor inside the oxygen storage and transfilling room by the south nurse's station and were not supported in a proper cylinder stand or otherwise secured from falling. The oxygen storage and transfilling room had three liquid oxygen containers and four 'E' type oxygen cylinders stored in the room. Based on interview at the time of the observations, the Administrator and the Support Services & Life Safety Manager agreed the four oxygen cylinders were not supported in a cylinder stand or otherwise secured from falling.	K 0923	**K 923** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1–There were four 'E' type Oxygen cylinders stored in room without racks, chains or other fastening to secure containers. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on south have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- Maintenance Director has installed an Oxygen container rack in O2 room for storage. **IV The facility will monitor**	05/12/2021

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	This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**the corrective action by implementing the following measures.** Maintenance Director will audit the Oxygen Room monthly to ensure all oxygen is stored in rack. See attached existing picture labeled "Oxygen Storage" **V. Plan of Correction completion date.** Plan of Completion date is May 12th, 2021.	