STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155193	A. BUILDING -- B. WING	07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTHCARE CENTER	377 WESTRIDGE BLVD 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: 07/05/22 Facility Number: 000101 Provider Number: 155193 AIM Number: 100291290 At this Emergency Preparedness survey, Greenwood Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 185 certified beds. At the time of the survey, the census was 172. Quality Review completed on 07/12/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/05/22 Facility Number: 000101 Provider Number: 155193 AIM Number: 100291290 At this Life Safety Code survey, Greenwood	K 0000		

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

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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	Healthcare Center 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in Room 339. The facility has battery operated smoke detectors installed in all resident sleeping rooms except Room 339. The facility has a capacity of 185 and had a census of 172 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 07/12/22			
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 record review, observation and interview; the facility failed to maintain latching hardware on 1 of 1 doors to the kitchen chemical storage room in accordance with LSC 4.6.12.3. LSC 4.6.12.3 requires existing life safety features	K 0100	**K100** It is the policy of this facility to provide latching hardware on doors.	07/24/2022

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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 2 staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, the door to the kitchen chemical storage room would not latch into the door frame when tested to close multiple times. The face of the door kept hitting the door frame when tested to close multiple times. Based on interview at the time of the observations, the Director of Maintenance provided "Proposal" documentation dated 06/22/22 from a construction contractor for the installation of new doors in the facility which includes the kitchen chemical storage room. The Director of Maintenance also provided "Purchase Order" documentation dated 06/28/22 from the facility agreeing to the contractor Proposal. Based on interview at the time of the observations and of the review of the Purchase Order documentation, the Director of Maintenance stated the kitchen chemical storage room door is on order and due for replacement. Based on interview at the time of the observations, the Director of Maintenance agreed the kitchen chemical storage room door failed to latch into the door frame when tested to close multiple times. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The door issue was identified prior to the Life Safety Inspection. Proposals were obtained and approved prior to entrance. Facility is just waiting for new doors to arrive and be installed. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors are allowed in this area. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Doors are checked monthly to ensure they close accordingly. This deficiency was identified prior with appropriate action taken to fix the situation. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on how to properly check fire doors for appropriate closure.	

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			4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 7/24/2022	
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories			

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	sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.			
	Based on record review, observation and interview; the facility failed to maintain the building construction type for Type V(111) construction in 1 of over 8 fire walls. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the fire door set by resident sleeping Room 214. Findings include: Based on review of "Fire/Smoke Doors" floor plan documentation with the Director of Maintenance during record review from 8:50 a.m. to 12:00 p.m. on 07/05/22, the fire door location identified as "#8" is located by resident sleeping Room 214. Based on observations with the Director of Maintenance during a tour of the facility from	K 0161	**K161** It is the policy of this facility to provide appropriate Fire Barriers. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by this alleged deficiency. Drywall was installed in the identified are. 2. How will other residents having the same potential to be	07/24/2022

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	12:45 p.m. to 3:20 p.m. on 07/05/22, a two foot by two section of drywall was missing above the suspended ceiling above the corridor door set by Room 214. The missing drywall section was on the north side of the wall studs above the door set and exposed the wood studs of the fire wall. In addition, drywall was missing below the two foot by two foot opening in the north wall above the door frame above the suspended ceiling to protect the horizontal wood framing of the wall. Based on interview at the time of the observations, the Director of Maintenance agreed the north side of the wall studs above the door set above the suspended ceiling by Room 214 was not protected to maintain the building construction type. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		affected by the alleged deficient practice be identified and what corrective action will be taken? The areas above the suspended ceilings over the fire doors were inspected with no other identified areas. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The areas above the suspended ceilings over the fire doors will be inspected monthly to ensure there are no disturbances to the fire walls and repaired accordingly. Maintenance will be inserviced by 7/24 on how to inspect fire walls. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that areas above the suspended ceilings over the fire doors are inspected monthly. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached.	

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			5. By what date will systemic changes be completed? 7/24/2022	
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			

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	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 1 exits in the courtyard outside Room 227 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	K 0222	**K 222** It is the policy of this facility to provide exits at Egresses. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?	07/24/2022

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	accordance with 19.2.2.2.5.2. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the courtyard by Room 227. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, the exit door by Room 227 discharges into an outdoor courtyard. The outdoor courtyard has one locked gated exit door in the courtyard fence which could be opened by entering a four digit code into a keypad at the gated exit door but the code was not posted at the courtyard exit door. Based on interview at the time of the observations, the Director of Maintenance stated the code was not posted at the courtyard gated exit because some residents are an elopement risk but stated not all residents in the health care portion of the facility have a clinical diagnosis to be in a secure wing and agreed the code was not posted at the exit door in the fence for the courtyard. The Director of Maintenance stated the code had been previously posted but was removed because a previous Life Safety Code surveyor said it was okay to not post the code at the courtyard fence exit door. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		This gate does automatically unlock when fire alarm is activated and when there is no power. The code has been posted accordingly. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by this alleged deficiency. The code has been posted no other areas identified during inspection. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The gate in the courtyard will be inspected monthly to ensure code is posted. Staff educated as to where to find posted code. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that code is posted monthly. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has	

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			not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 7/24/2022	
K 0321 SS=D 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			

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	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 11 hazardous areas such as 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 over 2 staff and visitors in the vicinity of the boiler room in the service corridor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, the corridor door to the boiler room in the service hall was equipped with a self closing device but the door failed to fully self close and latch into the door frame when the door was tested to close multiple times. The boiler room contained natural gas fired boilers and water heaters. Based on interview at the time of the observations, the Director of Maintenance agreed the door failing to self close and latch into the door frame did not separate this hazardous area from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)	K 0321	**K 321** It is the policy of this facility to provide enclosures/latches on doors. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The door issue was identified prior to the Life Safety Inspection. Proposals were obtained and approved prior to entrance. Facility is just waiting for new doors to arrive and be installed. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors are allowed in this area. Proposal obtained and new door ordered. All boiler room doors were inspected and any issues identified corrected. 3. What measures will be put	07/24/2022

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			into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Doors are checked monthly to ensure they close accordingly. This deficiency was identified prior with appropriate action taken to fix the situation. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on how to properly check Boiler doors for appropriate closure. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 7/24/2022	

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING 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 maintain the ceiling construction in three exterior canopies in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 30 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, an escutcheon	K 0351	**K 351** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by this alleged deficiency. Sprinkler company contacted to install missing escutcheons. 2. How will other residents having the same potential to be	07/24/2022

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GREENWOOD HEALTHCARE CENTER	377 WESTRIDGE BLVD 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
	was missing for the exterior canopy mounted sprinklers in the following locations: a. outside the southeast exit door for the main dining room. b. outside the exit door by resident sleeping Room 227. c. two sprinkler locations outside the exit door by resident sleeping Room 330. Based on interview at the time of the observations, the Director of Maintenance agreed each of the aforementioned ceiling mounted sprinkler locations was missing its escutcheon which did not completely cover the annular space surrounding the sprinkler. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		affected by the alleged deficient practice be identified and what corrective action will be taken? An audit was completed of all mounted sprinklers around the outside of the building of all overhangs. No other missing escutcheons were found. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Escutcheons will be replaced accordingly. No other missing escutcheons were found. Maintenance has been educated on appropriate inspection of mounted fire sprinklers. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that sprinklers are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic	

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			changes be completed? 7/24/2022	
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 Based on observation and interview, the facility failed to ensure 2 of 33 portable fire extinguishers was 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. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained 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 inspections have been performed. This deficient practice could affect	K 0355	**K 355** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The extinguishers were immediately inspected and taken care of accordingly. No residents were affected by this alleged deficiency. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents have the potential to be affected by the alleged deficiency. Facility wide sweep completed of all fire extinguishers	07/24/2022

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	over 10 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, the ABC type portable fire extinguisher located in the Activities Room and in the Therapy Room by the exit door to the outside of the facility each had an affixed maintenance tag indicating the annual inspection for the extinguishers was performed by the inspection contractor in November 2021. The affixed maintenance tag for each fire extinguisher was missing a documented monthly inspection for the one month period of June 2022. Based on interview at the time of the observations, the Director of Maintenance agreed portable fire extinguisher documentation for the aforementioned one month period was not available for review. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		with no other issues identified. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Fire extinguishers are inspected monthly and marked accordingly. Maintenance has been educated on how to properly inspect and mark extinguishers, including those in therapy and activities. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that extinguishers are inspected and marked monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 7/24/2022	
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	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. 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 review, observation and interview; the facility failed to ensure 3 of 6 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 30 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, the corridor smoke barrier door set by resident sleeping Room 105, by Room 121 and by Room 133 would not fully close leaving a gap of greater than 1/8 inch at the meeting edges of the door sets. Based on interview at the time of the observations, the Director of Maintenance provided "Proposal"	K 0374	**K374** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The smoke door issue was identified prior to the Life Safety Inspection. Proposals were obtained and approved prior to entrance. Facility is just waiting for new doors to arrive and be installed. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors were	07/24/2022

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	documentation dated 06/22/22 from a construction contractor for the installation of new smoke doors for the aforementioned three smoke door locations. The Director of Maintenance also provided "Purchase Order" documentation dated 06/28/22 from the facility agreeing to the contractor Proposal. Based on interview at the time of the observations and of the review of the Purchase Order documentation, the Director of Maintenance stated the doors are on order and are due for replacement. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		affected. There are other smoke doors that are affected with replacements ordered. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Doors are checked monthly to ensure they close accordingly. This deficiency was identified prior with appropriate action taken to fix the situation. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on how to properly check smoke doors for appropriate closure. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed?	

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K 0511 SS=D 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 Based on observation and interview, the facility failed to ensure electrical receptacles in 1 of over 75 resident sleeping rooms were properly wired and grounded in accordance with NFPA 70. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor.	K 0511	**K511** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The outlets were properly grounded. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by this alleged deficiency. All residents have the potential to be affected. All outlets have been tested with no other issues identified. 3. What measures will be put into place or systemic changes	07/24/2022

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	Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect one resident and staff in resident sleeping Room 318. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, two of four electrical receptacles in the wall mounted outlet box at the head of the bed in the south wall of resident sleeping Room 318 were each found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. The two receptacles in the outlet box with the open ground were nearest the window in the room. Based on interview at the time of the observations, the Director of Maintenance agreed the testing device showed the aforementioned electrical receptacles needed repair. This finding was reviewed with the Division		will be made to ensure that the alleged deficient practice does not occur? Resident room outlets as assigned through TELS are inspected annually. Maintenance Staff educated on proper electrical inspection and repair. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that outlets are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 7/24/2022	

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	Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)			
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on record review, observation and interview; the facility failed to ensure smoking materials were deposited into ashtrays and metal	K 0741	**K741**	07/24/2022

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	containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over 5 staff and visitors in the vicinity of the outdoor staff smoking area at the ambulance entrance on the east side of the facility near the kitchen exit door to the outside of the facility. Findings include: Based on review of "Smoking Campus" documentation with the Director of Maintenance during record review from 8:50 a.m. to 12:00 p.m. on 07/05/22, assessed residents and staff are allowed to smoke in designated outdoor smoking areas. Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, well over 50 cigarette butts were strewn on the ground outside the facility all along the concrete path of the ambulance entrance near the kitchen exit door to the outside of the facility on the east side of the building. Ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were provided at this outdoor location where staff smoking was taking place but extinguished cigarette butts were not consistently deposited into the designated containers. Based on interview at the time of the observations, the Director of Maintenance agreed cigarette butts were deposited on the ground all along the ambulance entrance path outside the building and were not consistently deposited into the ashtrays and metal containers with self-closing cover devices into which were provided at this outdoor location where staff smoking was taking place.		1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? All cigarette butts were cleaned up 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors were affected. All cigarette butts will be picked up daily by maintenance /or designee. Disciplinary action will be taken for those that do not utilize proper receptacle to dispose of smoking materials. Any issues will be immediately addressed. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? A cigarette butt receptacle is located in this area. Maintenance will clean this area daily during normal business days to ensure cigarette butts are picked up and disposed of accordingly. All staff to be inserviced by 7/24/22 on proper disposal of cigarette butts. 4. How will the corrective action	

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	This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that butts are disposed of properly daily. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 7/24/2022	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; it could not be assured annual inspection and testing documentation for 3 of over 12 fire door locations in the facility indicated fire doors were properly maintained in accordance of NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, Section 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the	K 0761	**K761** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Paint was removed from label of the identified door. The door issue was identified prior to the Life Safety Inspection. Proposals were obtained and approved prior to entrance for other identified door #1. Facility is just waiting for new doors and hardware to arrive and	07/24/2022

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	inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect over 30 residents, staff and visitors. Findings include: Based on review of "Fire/Smoke Door Inspection" documentation dated 08/01/21 with the Director of Maintenance during record review from 8:50 a.m. to 12:00 p.m. on 07/05/22, the fire door location identified as "Main Entrance #5" had no documented deficiencies. Review of "Fire/Smoke Doors" floor plan documentation indicated fire door #5 was a cross corridor door in the main entrance lobby which separated the main entrance lobby from the corridor leading to the main dining room. Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, the fire resistance rating label affixed to the hinge side of the west door in the corridor door set in the main entrance lobby was painted and not legible. Based on interview at the time of the observations, the Director of Maintenance stated he did not state any deficiencies on the 08/01/21 inspection for fire door #5 because the 1.5 hour fire resistance rating label for the east door in the corridor door set was not painted and is legible but agreed the fire resistance rating label for the west door in the door set was painted and not legible. In addition, the two fire door locations identified as "#1" by Room 137 and as #6 by the 200 Hall main entrance on the "Fire/Smoke Doors" floor plan were each a cross corridor door set. Each door in the door set was equipped with a 90 minute fire resistance rating label on the hinge side of the door. The latching hardware on each door for fire door location #1 failed to latch the		be installed. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors were affected. All doors were inspected and labels were legible. Other identified doors with issues have ordered and waiting for new doors and hardware to arrive and be installed. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Doors are checked monthly to ensure labels are legible. Doors are checked monthly to ensure they close accordingly. This deficiency was identified prior with appropriate action taken to fix the situation. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on how to properly check fire doors for appropriate closure, legible rating labels and to document issues found accordingly. 4. How will the corrective action be monitored to ensure the alleged	

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	door into the door frame when tested to close multiple times. A one inch gap was noted in between the meeting edges of the fire door set at the 200 Hall main entrance when tested to close multiple times. Based on interview at the time of the observations, the Director of Maintenance provided "Proposal" documentation dated 06/22/22 from a construction contractor for the installation of new fire doors for the aforementioned fire door locations. The Director of Maintenance also provided "Purchase Order" documentation dated 06/28/22 from the facility agreeing to the contractor Proposal. Based on interview at the time of the observations and of the review of the Purchase Order documentation, the Director of Maintenance stated the doors are on order and are due for replacement. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected and issues documented accordingly monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 7/24/2022	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING 01 B. WING	07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTHCARE CENTER	377 WESTRIDGE BLVD 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
	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 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 1 of 1 cylinders of nonflammable gases were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained	K 0923	**K 923** 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The identified cylinder was removed and stored appropriately.	07/24/2022

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	or supported in a proper cylinder stand or cart. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the soiled utility room across from the 300 Hall nurse's station. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:20 p.m. on 07/05/22, one 'E' type oxygen cylinder was standing upright on the floor in the soiled utility room across from the 300 Hall nurse's station and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Director of Maintenance agreed the 'E' type oxygen cylinder stored in the aforementioned soiled utility room was not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Division Facilities Manager and the Director of Maintenance during the exit conference. 3.1-19(b)		2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors were affected. Facility sweep of all soiled utility rooms was conducted with no identified issues. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Maintenance and /or Designee will make rounds 3x weekly to ensure cylinders are being stored accordingly. All staff inserviced on appropriate storage of oxygen cylinders. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that oxygen cylinders are stored appropriately. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached.	

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			5. By what date will systemic changes be completed? 7/24/2022	