PRINTED: 08/17/2022

DEPARTMENT OF HEALTH AND HU	EPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED									
CENTERS FOR MEDICARE & MEDI	CAID SERVICES				OM	B NO. 0938-039				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	UPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE	SURVEY					
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u></u>	COMPL	ETED				
	155412	B. WI	NG	_	07/19/	2022				
NAME OF PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP COD Y RD	•					
GREENWOOD HEALTH AND LIVING COMMUNITY			GREEN	IWOOD, IN 46142						

GREEN'	WOOD HEALTH AND LIVING COMMUNITY		937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX TAG = 0000 Bldg	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION An Emergency Preparedness Survey was	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) August 8, 2022	(X5) COMPLETION DATE			
	conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/19/22 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Emergency Preparedness survey,		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: ULTN21 Dear Mrs. Buroker: Please find enclosed the Plan of				
	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 93.		Correction for the State Licensure Survey conducted on July 19th, 2022. 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				
	Quality Review completed on 07/25/22		on August 8, 2022. 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,				
			Dan Kern, HFA 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				

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/19/2022			
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				report is a true and accurate portrayal of the provision of no care or other services provided this facility. The Plan of Corre is prepared and executed sole because it is required by Federand State Law. This statement deficiencies and plan of correwill be reviewed at the Monthl Quality Assurance/Assessme Committee meeting.	ed in ction ely eral eral et of ction		
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 07/19 Facility Number: 0 Provider Number: 1002 At this Life Safety 0 Health And Living compliance with Re Medicare/Medicaid Life Safety from Fin National Fire Protect Life Safety Code (L) Health Care Occupation This one story facility Type V (111) const. The facility has a findetection in the corresponding to the safety for the safety for the safety facility for the safety	00509 155412	K 0000	August 8, 2022 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: ULTN21 Dear Mrs. Buroker: Please find enclosed the Plan Correction for the State Licen Survey conducted on July 19t 2022. This letter is to inform y that the plan of correction attached is to serve as Green Health & Living Community credible allegation of complian We allege substantial complia on August 8, 2022. We are requesting paper compliance this plan of correction. If you h any further questions, please not hesitate to contact me at 317-796-9776.	sure th, rou wood nce. ance for nave		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction (X3) DATE SURVEY COMPLETED 07/19/2022			
	PROVIDER OR SUPPLIEF	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	rooms. The facility a census of 93 at the All areas where residence were sprinklered. The buildings providing which were not springle.	idents have customary access The facility has two detached facility storage services		Sincerely, Dan Kern, HFA Administrator Greenwood Healt 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 sur report is a true and accurate portrayal of the provision of nur care or other services provided this facility. The Plan of Correct is prepared and executed solely because it is required by Feder and State Law. This statement deficiencies and plan of correct will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	vey sing in ion y al of ion		
K 0100 SS=E Bldg. 01	Section 18.1 and that are not addre K-tags, but are de along with the app NFPA standard ci on Form CMS-256 Based on observation failed to maintain lasets to the north din 4.6.12.3 requires expobious to the publication and the section of the secti	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included	K 0100	K- 100 what corrective action(s) will be accomplished for thos residents found to have been affected by the deficient practice:			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			COMPLETED
		155412	B. W	ING		07/19/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF P	ROVIDER OR SUPPLIER			937 FR		
GREENW	VOOD HEALTH AN	D LIVING COMMUNITY			IWOOD, IN 46142	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	•	ould affect over 20 residents,			Door latch has been repaired	and
		the vicinity of the north			door now properly latches	
	dining room.				- how other residents	
					having the potential to be	
	Findings include:				affected by the same deficien	nt
					practice will be identified and	d
	Based on observations with the Maintenance Director during a tour of the facility from 12:45				what corrective action(s) will	
					be taken;	
		n 07/19/22, the latching			All residents and staff of the r	north
	hardware for the east door in the door set serving as the entrance to the north dining room failed to latch the door into the door frame when tested to close multiple times. Based on interview at the				side of the facility have the	
					potential to be affected by the	
					deficient practice	
					- what measures will be p	
	time of the observations, the Maintenance				into place and what systemic	;
	Director agreed the east door in the door set failed				changes will be made to	
		or frame when tested to close			ensure that the deficient	
	multiple times.				practice does not recur;	
					The Maint Director has inspec	
	_	viewed with the Administrator			all doors to ensure proper latc	hing
		e Director during the exit			mechanism is in place and	
	conference.				functioning properly.	
	2.1.10(1)				- how the corrective	
	3.1-19(b)				action(s) will be monitored to	
					ensure the deficient practice	
					will not recur,	
					A TELS task is in place for the	;
					Maint director to inspect all	
					latching doors to ensure prope	er
					functioning.	-:-
					- by what date the system	
					changes for each deficiency	
					will be completed.	
					8/8/22	
K 0211	NFPA 101					
SS=F	Means of Egress -	- General				
Bldg. 01	Means of Egress -					
Diag. 01	Aisles, passagewa					
		cations, and accesses are				
	_	n Chapter 7, and the means				
	in accordance Will	i Onapiei 1, and the means				

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412		ILDING	onstruction 01	(X3) DATE S COMPLE 07/19/2	ETED
	F PROVIDER OR SUPPLIE	R ND LIVING COMMUNITY		937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	all obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7. Based on observatifailed to maintain to obstructions in 4 of 19.2.3.4(4) states, puidth shall be pern provided that all of met: (a) The wheeled equipart training program as wheeled equipment emergency. (c) The wheeled equipart following: i. Equipment in use ii. Medical emergency. This deficient pract staff and visitors if Findings include:	on and interview, the facility the means of egress free from the means of egress. LSC projections into the required mitted for wheeled equipment, the following conditions are unipment does not reduce the corridor width to less than 60 occupancy fire safety plan and ddress the relocation of the the during a fire or similar unipment is limited to the e and carts in use many equipment not in use transport equipment tice could affect all residents, meeding to exit the facility.	K 02	211	K- 211 - what corrective action(s will be accomplished for those residents found to have been affected by the deficient practice; All items have been moved to side of the hall in order to keep means of egress open and at 60 inches of clear space. All chairs were returned to the off they are stored in after cleaning was completed. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential be affected by the deficient practice	one oleast ices ig	08/08/2022
	Based on observations with the Maintenance Director during the initial walk through of the facility from 8:40 a.m. to 8:48 a.m. on 07/19/22, a plastic three drawer chest of drawers was stored				- what measures will be p into place and what systemic changes will be made to ensure that the deficient		
	in the corridor outs and Room 506. In carts were also stor Room 506. A whe of drawers was stor outside resident sle	ide resident sleeping Room 100 addition, two 32 gallon wheeled red in the corridor outside eled plastic three drawer chest red up against the corridor wall reping Room 505 opposite the red carts stored outside Room			practice does not recur; Staff have been educated to ensure hallways have a means egress and that all wheeled equipment must be removed fi hallways during an emergency Facility staff will ensure that al	rom /.	

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	OF CORRECTION	IDENTIFICATION NUMBER 155412	A. BUILDING B. WING	01	COMPLETED 07/19/2022		
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION DATE		
	A chair was stored in exit access at the exit access at the exit access at the exit accility in the 200 H outside the Adminis 200 Hall with each of the eight foot wide of stored in the corridor and Room 416. A listored in the corridor blocked nearly half Based on observation Director during a top.m. to 2:20 p.m. on drawers, chairs and the corridor during the facility were still stocleaning of the chain initial walk through afternoon. Based on observations, the Mithe chairs were bein because they were in but agreed all chest which were stored in the aforementioned obstructions. This finding was revand the Maintenance conference.	on both sides of the corridor. In the path of egress for the sit door to the outside of the sall. Six chairs were stored strator's office at the end of the chair projecting 18 inches into corridor. A chair was also or outside Room 106, Room 108 arge upholstered chair was also or outside Room 106 and of the eight foot wide corridor. On with the Maintenance our of the facility from 12:45 to 107/19/22, all the chest of carts observed being stored in the initial walk through of the ored in the corridor. No res was observed during the or the tour of the facility in the interview at the time of the aintenance Director stated all gestored in the corridor in the process of being cleaned of drawers, chairs and carts in the corridor did not maintain means of egress free from		items in the hall are to be son one side of the hallway of and that 60 inches of space always clear resident and somovement. - how the corrective action(s) will be monitored ensure the deficient practic will not recur, A TELS task has been enterensure that maintenance dischecks all means of egress to ensure items are stored side of the hallway through facility. - by what date the systic changes for each deficient will be completed. 8/8/22	only is is taff I to ce red to rector daily o one but the		
K 0222 SS=E Bldg. 01	be equipped with a	d means of egress shall not a latch or a lock that f a tool or key from the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		î ´	UILDING	nstruction 01	(X3) DATE COMPL 07/19/	LETED			
		ROVIDER OR SUPPLIER	ID LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
		egress side unless special locking arr CLINICAL NEEDS LOCKING Where special loc clinical security ne used, only one loc permitted on each be made for the raby: remote control locks or keys carriother such reliable staff at all times. 18.2.2.5.1, 18.2.19.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special loc safety needs of the the Clinical or Secare being met. In a electrical locks that release upon loss building is protected automatic sprinkle space is protected detection system at an attended loc space); and both the systems are arran upon activation. 18.2.2.2.5.2, 19.2.DELAYED-EGREARRANGEMENTS Approved, listed dessemblies servin contents in building contents in	s using one of the following rangements: S OR SECURITY THREAT king arrangements for the eds of the patient are cking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ited by staff at all times; or emeans available to the example of the example o					DATE	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01 COMPLETED				
		155412	B. W	NG		07/19/	2022
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY		937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDENCE N. IN OF CORPORATION			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	automatic sprinkle 18.2.2.2.4, 19.2.2. ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie throughout by an a automatic fire dete approved, supervi system. 18.2.2.2.4, 19.2.2. Based on observatic failed to ensure the 8 delayed egress loc all residents, staff a Delayed Egress Loc delayed egress lock installed on doors so hazard contents in be throughout by an ap fire detection syster Section 9.6, or an ap sprinkler system ins Section 9.7, and wh through 42, provide (a) The doors unloc approved, supervise installed in accorda the actuation of any than two smoke det supervised automatic	OLLED EGRESS NGEMENTS I Egress Door assemblies ance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 2.1.6.3 shall be permitted as in buildings protected approved, supervised action system and an sed automatic sprinkler 2.4 an and interview, the facility means of egress through 1 of acks were readily accessible for and visitors. LSC 7.2.1.6.1, acks allows approved, listed, as shall be permitted to be arriving low and ordinary buildings protected approved, supervised automatic an installed in accordance with approved, supervised automatic astalled in accordance with arriverse accordance with approved in Chapters 12	K 0	222	K- 222- Egress Door - what corrective action(s will be accomplished for thos residents found to have been affected by the deficient practice; Front doors now properly disengage after pushing for 15 seconds how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential be affected by the deficient practice - what measures will be pinto place and what systemic changes will be made to	se i nt i	08/08/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 07/19/2022			
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION		
	(b) The doors unloce controlling the lock (c) An irreversible part within 15 seconds with release device reaction of the release device reaction of the required to econtinuously applied. The initiation of the an audible signal in the door lock has been of force to the release by manual means of Exception: Where a having jurisdiction, seconds shall be per (d) On the door adjust the reads and the reads that reads: "PUSH UNTIL ALDOOR CAN BE Of This deficient pract residents, staff and facility. Findings include: Based on observation Director during a top.m. to 2:20 p.m. on the main entrance leavit with an exit sigmagnetically locked entering a four digit exit door set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or set was also easignage stating the cafter 15 seconds but a second or second o	k upon loss of power or locking mechanism. brocess shall release the lock upon application of a force to equired in 7.2.1.5.4 that shall exceed 15 lbf nor required to be d for more than 3 seconds. brelease process shall activate the vicinity of the door. Once the released by the application using device, relocking shall be only. In proved by the authority a delay not exceeding 30 mitted. Breach to the release device, the lily visible, durable sign in 1 inch high and at least 1/8 at on a contrasting background		ensure that the deficient practice does not recur; Maintenance director will ethat all exit doors function on a weekly basis. - how the corrective action(s) will be monitore ensure the deficient practive will not recur, A TELS task has been entensure that Maintenance dischecking all exit doors with to ensure proper functioning by what date the systemages for each deficient will be completed. 8/8/22	ensure properly d to tice ered to director reekly ng. stemic		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 01 COMPLETE			
		155412	B. W	ING		07/19/	2022
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	•	937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE					(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE.	DATE
K 0271	the observations, the he was not certain the delayed egress door equipped with delay not release to open a multiple times. This finding was revenue.	sed on interview at the time of the Maintenance Director stated the doors were arranged as the but agreed the doors were the yed egress signage and would the pushing for 15 seconds wiewed with the Administrator the Director during the exit					
SS=E Bldg. 01	Discharge from Ex Discharge from Ex Exit discharge is a 7.7, provides a lev the provisions of 7 changes in elevations discharge shall be travel surface. 18.2.7, 19.2.7 Based on observation		К 0	271	K- 271- Discharge from exit - what corrective action(s)	08/08/2022
	continuously mainta or impediments to fi fire or other emerge could affect over 20 needing to exit the f of the north dining r Findings include:	ained free of all obstructions will instant use in the case of ency. This deficient practice presidents, staff and visitors if facility from the southeast exit			will be accomplished for those residents found to have been affected by the deficient practice; Patio Furniture has been moved back so that it no longer blocks the full swing of the door as it opens. how other residents	se I	
		ur of the facility from 12:45			having the potential to be affected by the same deficier	nt	
	_	n 07/19/22, patio chairs and a			practice will be identified and		
		red in the means of egress in			what corrective action(s) will		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155412		A. BUILDING 01 COMPLETED B. WING 07/19/2022			
		130412	Б. W			07/19/	2022
NAME OF P	ROVIDER OR SUPPLIER			937 FR	ADDRESS, CITY, STATE, ZIP COD		
GREENV	VOOD HEALTH AN	D LIVING COMMUNITY			NWOOD, IN 46142		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION or the southeast exit from the		TAG			DATE
		which provided obstruction			be taken; Residents eating in the north		
		full instant use for the path of			dining room have the potential	l to	
	-	scharge. Based on interview at			be affected by the deficient		
		rvations, the Maintenance			practice.		
	-	patio table and chairs in the			- what measures will be p		
		d provide an impediment to full			into place and what systemic	;	
	instant use in the case of fire or other emergency. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)				changes will be made to ensure that the deficient		
					practice does not recur;		
					Maintenance director will mon	itor	
					all exit doors to ensure that the		
					are free from obstructions whe	∍n	
					swinging open.		
					- how the corrective		
					action(s) will be monitored to		
					ensure the deficient practice will not recur,		
					A TELS task has been created	d to	
					ensure that Maintenance direc	ctor	
					is checking all exit doors week	dy	
					to ensure they are free from		
					obstructions.		
					by what date the systemic		
					changes for each deficiency will be completed. 8/8/22		
					So completed. 0/0/22		
K 0291	NFPA 101						
SS=F	Emergency Lightir	•					
Bldg. 01	Emergency Lightin	_					
		g of at least 1-1/2-hour					
	duration is provide accordance with 7	-					
	18.2.9.1, 19.2.9.1						
		view, observation and	K 0	291	K- 291- Emergency Lighting		08/08/2022
	· ·	ty failed to ensure 1 of 3			(documentation)		-
		ergency lighting systems was			- what corrective action(s		
		dance with LSC 7.9. LSC			will be accomplished for tho		
		y operated emergency lights			residents found to have been	1	
	shall use only reliab	le types of rechargeable	1		affected by the deficient	ļ	

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NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/19/2022
PROVIDER OR SUPPLIEI	ID LIVING COMMUNITY	937 FF	ADDRESS, CITY, STATE, ZIP COI RY RD NWOOD, IN 46142	
SUMMARY (EACH DEFICIENT REGULATORY OF DETICIENT REGULA	EXAMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION with suitable facilities for a properly charged condition. Inch lights or units shall be intended use and shall comply it conal Electric Code. This could affect all residents, staff The Battery-operated Emergency in Year: 2021" documentation in ELS Logbook Documentation in Els Logb	STREET 937 FF	PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY) practice; A battery has been instated the light above the emergenerator to ensure that proper lightinghow other residents have the potential to be affect the same deficient practice deficient practice action(s) will taken; All residents have the potential to be affected be deficient practice - what measures will into place and what system changes will be made to ensure that the deficient practice does not recur Maintenance director will that all emergency lights properly on a weekly bast how the corrective action(s) will be monito ensure the deficient practice does not recur will not recur, A TELS task has been controlled.	CITION (X5) COMPLETION DATE Illed on gency it has aving sted by tice will be put stemic out; I ensure function sis ared to actice reated to continue to the c
three battery operat noted in the facility light functioned wh	ed lighting systems were and each battery operated ten its respective test button for the battery operated light		ensure the maintenance checks all emergency lig weekly basis. by what date the s	director hts on a
located on the north emergency generate building. Based on observations, the M the aforementioned lighting system fail	a wall of the building at the or location outside the interview at the time of the laintenance Director agreed battery powered emergency ed to illuminate when its on was pushed multiple times.		changes for each defici will be completed. 8/8/2	ency
This finding was re	viewed with the Administrator			

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	l í	UILDING	nstruction 01	(X3) DATE COMPI 07/19	LETED
	PROVIDER OR SUPPLIER	ID LIVING COMMUNITY		937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD WOOD, IN 46142		
(X4) ID		STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	BIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and the Maintenanc conference.	e Director during the exit					
	3.1-19(b)						
K 0321	NFPA 101						
SS=E	Hazardous Areas						
Bldg. 01	Hazardous Areas						
		are protected by a fire					
	-	our 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							
		tic fire extinguishing system					
option is used, the areas shall be separated		areas shall be separated					
		by smoke resisting					
	•	rs in accordance with 8.4.					
	Doors shall be sel						
	_	and permitted to have					
		applied protective plates that inches from the bottom of					
	the door.	inches from the bottom of					
		and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation						
		-Fired Heater Rooms					
	` •	er than 100 square feet) nance, and Paint Shops					
		nance, and raint Shops noms (exceeding 64					
	gallons)	Joins (exceeding 04					
	e. Trash Collection	n Rooms					
	(exceeding 64 gal						
	, ,	orage Rooms/Spaces					
	(over 50 square fe	et)					
	- '	classified as Severe					
	Hazard - see K32	2)					

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 155412 07/19/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 937 FRY RD GREENWOOD HEALTH AND LIVING COMMUNITY GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observation and interview, the facility K 0321 K- 321 Hazardous Area enclosure 08/08/2022 failed to ensure 1 of over 6 hazardous areas such what corrective action(s) as soiled linen and trash collection rooms were will be accomplished for those separated from other spaces by smoke resistant residents found to have been partitions and doors. Doors shall be self closing affected by the deficient or automatic closing in accordance with 7.2.1.8. practice; This deficient practice could affect over 10 Maintenance director placed residents, staff and visitors in the vicinity of the appropriate fire rated caulk in the Soiled Utility Room by Room 209. hole between soiled UTL and room 209. Findings include: how other residents having the potential to be Based on observations with the Maintenance affected by the same deficient Director during a tour of the facility from 12:45 practice will be identified and p.m. to 2:20 p.m. on 07/19/22, the annular space what corrective action(s) will surrounding a three inch in diameter capped water be taken: line which penetrated the wall of the Soiled Utility Residents living on the 200 hall Room by Room 209 was not firestopped. Based have the potential to be affected on interview at the time of the observations, the by the deficient practice. Maintenance Director agreed the aforementioned what measures will be put opening in the Soiled Utility Room wall did not into place and what systemic separate this hazardous area from other spaces changes will be made to with smoke resistant partitions and doors. ensure that the deficient practice does not recur; This finding was reviewed with the Administrator Fire caulk that was installed and the Maintenance Director during the exit ensured that the deficient practice conference. will not recur. how the corrective 3.1-19(b) action(s) will be monitored to ensure the deficient practice will not recur, Photograph (attached to POC) of installed fire caulk demonstrates that deficient practice has been resolved and will not recur. by what date the systemic changes for each deficiency

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will be completed. 8/8/22

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155412	B. W	ING		s (s) will nose re been nt as ensured place an ole during Requested annual kitchen fire	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8		937 FR			
GREENV	VOOD HEALTH AN	ID LIVING COMMUNITY			NWOOD, IN 46142		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
K 0324	NFPA 101						
SS=D	Cooking Facilities						
Bldg. 01	Cooking Facilities						
	Cooking equipme	· · · · · · ·					
		NFPA 96, Standard for					
	Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:						
* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited							
	_	ance with 18.3.2.5.2,					
	19.3.2.5.2						
	* cooking facilities open to the corridor in smoke compartments with 30 or fewer						
	•						
		rith the conditions under					
	18.3.2.5.3, 19.3.2						
	-	in smoke compartments					
	· ·	atients comply with					
		18.3.2.5.4, 19.3.2.5.4.					
		protected according to					
	•	3 are not required to be					
		rdous areas, but shall not					
	be open to the co	n 18.3.2.5.4, 19.3.2.5.1					
	through 19.3.2.5.5						
		review and interview, the	K 0	324	K- 324 Cooking facilities		08/08/2022
		sure 1 of 1 kitchen fire	K 0	<i>32</i> 1	-what corrective action(s) wi	11	00/00/2022
		s was inspected semiannually.			be accomplished for those		
	* *	ition, Standard for Ventilation			residents found to have been	n	
	· ·	otection of Commercial			affected by the deficient	•	
		s, Section 11.2.1 states			practice;		
		fire-extinguishing systems and			maintenance director has ens	ured	
		s containing a constant or			that Metal drip pan is in place		
		system that is listed to			below range hood and an		
		the grease removal devices,			additional pan is available dur	ing	
	_	ms, and the exhaust ducts			cleaning of other pan. Reques	-	
	_	operly trained, qualified, and			documentation of semi-annua		
		acceptable to the authority			report for inspection of kitcher		
		at lease every six months.			suppression system between		
		ice could affect over three staff			21 and feb 22. Will send in wi		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	01	COMPLETED
		155412	B. W	ING		07/19/2022
NAME OF I	PROVIDER OR SUPPLIEF	· :			ADDRESS, CITY, STATE, ZIP COD	•
GREENV	WOOD HEALTH AN	ID LIVING COMMUNITY		937 FR GREEN	IY RD NWOOD, IN 46142	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE NEARLOS CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	and visitors in the k	ritchen.			we receive.	
					- how other residents	
	Findings include:				having the potential to be	
					affected by the same deficie	nt
		the kitchen fire suppression			practice will be identified an	d
		contractor's inspection			what corrective action(s) wil	I
		ed 02/18/21 and 02/01/22 with			be taken;	
		nd the Maintenance Assistant			All residents have the	
	during record review from 8:50 a.m. to 12:50 p.m.				potential to be affected by the	
	on 07/19/22, documentation of semiannual fire				deficient practice	
	suppression system inspection six months after					
	02/18/21 was not available for review. Based on				- what measures will be	
	interview at the time of record review, the				into place and what systemi	С
	Administrator and the Maintenance Director				changes will be made to	
	_	ion of semiannual fire			ensure that the deficient	
		inspection six months after			practice does not recur;	
	02/18/21 was not av	vailable for review.			Maint Director will ensure that	
					are scheduled to have semi a	nnual
	_	viewed with the Administrator			inspections of the kitchen fire	
		ee Director during the exit			suppression equipment and the	nat
	conference.				all documentation is in the	
					maintenance binder upon rec	eipt
	3.1-19(b)				of completion.	
					- how the corrective	
		ation and interview, the facility			action(s) will be monitored t	
		he kitchen range hood system			ensure the deficient practice	
		the requirements of LSC 9.2.3.			will not recur, A TELS task h	
		commercial cooking			been created to semi annually	
		installed in accordance with			remind maintenance director	
		for Ventilation Control and			check for completion of kitche	en
		Commercial Cooking			fire suppression equipment.	rin
	_	96, 2011 edition, Section 6.2.4.1			Dietary Director will ensure Di	lib
	_	hood system filters shall be			pan is in place.	min
		p tray beneath their lower			- by what date the system	
		all be kept to the minimum size			changes for each deficiency	
	_	rease and shall be pitched to			will be completed. 8/8/22	
		sed metal container having a				
		ling 1 gal (3.785 L). This				
	-	ould affect over three staff and				
	visitors in the kitch	en.	1		i .	l I

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	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER 155412	A. BUILDING B. WING	01	COMP	LETED 0/2022
	ROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZIP CO RY RD NWOOD, IN 46142	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Findings include:					
	Director during a top.m. to 2:20 p.m. on designated locations range hood system of enclosed metal cont. The designated local had a one half inch is tray beneath the system container was in plattime of the observat. Director agreed the underneath the kitch tray was missing its grease to drain into. This finding was revenue.	nen range hood system drip enclosed metal container for				
K 0353 SS=F Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an	Maintenance and Testing Maintenance and Testing r and standpipe systems ted, and maintained in IFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, ting are maintained in a Id readily available. System last checked System test				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<u>01</u>	COMPL	
		155412	B. W	ING		07/19/	2022
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	c) Water system	supply source					
	Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, 1. Based on record of facility failed to ma systems in accordar requires all sprinkle tested, and maintain 25, Standard for the Maintenance of Wa Systems. NFPA 25 states each control of annually through its normal position. No post indicator valve or torsion is felt in thas not become deta 25, Section 4.1.4.1 designated represendeficiencies or impathe inspection, test at this standard. Correperformed by qualified contractor records shall be made and maintenance of shall be made availating jurisdiction upon recould affect all residuals. Findings include: Based on review of	RKS information on non-required or partial or system. and NFPA 25 review and interview, the intain automatic sprinkler are with NFPA 25. LSC 9.7.5 or systems shall be inspected, and in accordance with NFPA Inspection, Testing, and ter-Based Fire Protection, 2011 Edition, Section 13.3.3.1 valve shall be operated as full range and returned to its FPA 25, Section 13.3.3.2 state as shall be opened until spring the rod, indicating that the rod and ached from the valve. NFPA states the property owner or tative shall correct or repair airments that are found during and maintenance required by actions and repairs shall be and maintenance personnel or or. NFPA 25, 4.3.1 requires de for all inspections, tests, the system components and table to the authority having quest. This deficient practice dents, staff, and visitors in the or's "Quarterly Water-Based tems Inspection"	K 0	353	K- 353 - what corrective action(s will be accomplished for thoresidents found to have been affected by the deficient practice; PIV valve has been repaired. year sample test has been completed on 8/15/2022. Cinta completed 20 year inspection. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential be affected by the deficient practice - what measures will be printo place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director ensured Lock was placed on PIV valve Maintenance director requested year sample test be conducted and is awaiting visit from CINT complete. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur,	se 1 20 as that a ded 20 dd TA to	08/08/2022

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE (A. BUILDING B. WING	construction 01	(X3) DATE SURVEY COMPLETED 07/19/2022	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 F	r address, city, state, zip cod RY RD NWOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
TAG	Administrator and the during record review on 07/19/22, deficite facility's Post Indica Service Mains" sect system inspection root "Valves exercise proper operation (12 at the time of record Director stated the facorrections being madocumentation of Pafter 05/09/22 was to the Maintenance conference. 3.1-19(b) 2. Based on record facility failed to masystems in accordar requires all sprinkle tested, and maintain 25, Standard for the Maintenance of Wasystems. NFPA 25 states sprinklers masafast-response element for 20 years shall be samples shall be test year intervals. NFF property owner or decorrect or repair defare found during the maintenance required corrections and rep qualified maintenance required maintenance required maintenance required maintenance required maintenance required maintenance maintenance required maintenance main	the Maintenance Director of from 8:50 a.m. to 12:25 p.m. cencies were noted for the ator Valve (PIV). The "Fire ation of the 05/09/22 sprinkler export stated "Fail" in response d through full range to ensure 3.3.3.2)". Based on interview d review, the Maintenance facility was working on ade to the PIV and stated IV repair or replacement on or not available for review. In viewed with the Administrator wiewed with the Administrator wiewed with NFPA 25. LSC 9.7.5 In review and interview, the intain automatic sprinkler face with NFPA 25. LSC 9.7.5 In systems shall be inspected, fined in accordance with NFPA Inspection, Testing, and ter-Based Fire Protection for 2011 Edition, Section 5.1.1.1.3 Infactured using fines that have been in service for explaced, or representative for the day of the rested at 10 for 25, Section 4.1.4.1 states the for explaced representative shall for energy of the protection of the properties of	TAG	Lock in place ensures that PI valve will not be used and no longer needs to be monitored Maintenance director will followith CINTAS to get update or when they will be out to comptest. We have also contacted PIPE to seek their assistance completing the test as well. - by what date the system changes for each deficiency will be completed. 8/8/22	DATE V I. Dow up Diete I Diete	

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	OF CORRECTION	IDENTIFICATION NUMBER 155412	JILDING	01	COMPL 07/19/	ETED
	PROVIDER OR SUPPLIER	RID LIVING COMMUNITY	937 FR	NDDRESS, CITY, STATE, ZIP COD Y RD WOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	be made available to jurisdiction upon recould affect all residual facility. Findings include: Based on review of inspection contractor Fire Protection Syst documentation date Administrator and to during record review on 07/19/22, deficite facility's wet and dreferencies system inspection rest due in response elements in been replaced or sare "Mechanical room accontractor's "Service 11/03/21 stated "Could both wet and dry system the time of record rec	system components and shall of the authority having equest. This deficient practice dents, staff, and visitors in the dents, staff, and visitors in the or's "Quarterly Water-Based tems Inspection" at 11/03/21 with the define Maintenance Director we from 8:50 a.m. to 12:25 p.m. encies were noted for the ry sprinkler systems. The ston of the 11/03/21 sprinkler eport stated "20 year sample e to "Sprinklers with fast in service for 20 years have emple tested" for the eacross 203". Review of the eacross 203". Review of the eacross 203". Review of the eacross 203" as a sample test for estems. Based on interview at eview, the Maintenance facility was working on eade and stated documentation sting on or after 11/03/21 was				
K 0355 SS=E	NFPA 101 Portable Fire Extir	nguishers				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155412 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 937 FRY RD GREENWOOD HEALTH AND LIVING COMMUNITY GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 01 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 K 0355 K- 355-08/08/2022 failed to ensure 1 of 18 portable fire extinguishers what corrective action(s) had pressure gauge readings in the acceptable will be accomplished for those range. LSC 19.3.5.12 states portable fire residents found to have been extinguishers shall be provided in all health care affected by the deficient occupancies in accordance with 9.7.4.1. LSC practice; 9.7.4.1 states where required by the provisions of Fire Extinguisher has been another section of this Code, portable fire recharged and is in compliance. extinguishers shall be selected, installed, how other residents inspected, and maintained in accordance with having the potential to be NFPA 10, the Standard for Portable Fire affected by the same deficient Extinguishers. NFPA 10, 2010 Edition, Section practice will be identified and 7.2.2(3) states the periodic monthly check shall what corrective action(s) will ensure the pressure gauge reading or indicator is be taken; in the operable range or position. Section 7.2.3.1 All residents have the potential to states when an inspection of any rechargeable fire be affected by the deficient extinguisher reveals a deficiency listed in 7.2.2(3), practice the extinguisher shall be subjected to applicable what measures will be put maintenance procedures. This deficient practice into place and what systemic could affect over 10 residents, staff and visitors in changes will be made to the vicinity of the laundry room. ensure that the deficient practice does not recur; Findings include: Maintenance director will ensure that all Portable fire extinguishers Based on observations with the Maintenance are properly charged on a monthly Director during a tour of the facility from 12:45 basis. p.m. to 2:20 p.m. on 07/19/22, the pressure gauge how the corrective for the wall mounted portable ABC type fire action(s) will be monitored to extinguisher located near the dryers near the ensure the deficient practice entrance door to the laundry room from the 200 will not recur. Hall showed the extinguisher was undercharged. A TELS task has been created to Based on interview at the time of the remind Maintenance director to observations, the Maintenance Director agreed check all fire extinguishers the portable fire extinguisher pressure gauge monthly and document on the

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	JILDING	onstruction 01	(X3) DATE COMPL 07/19/	ETED
	PROVIDER OR SUPPLIER		937 FR			
GREEN	WOOD HEALTH AN	D LIVING COMMUNITY	GREEN	IWOOD, IN 46142		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	showed the extingu	isher was undercharged.		attached tag ensuring proper		
		viewed with the Administrator e Director during the exit		charge. by what date the systemic changes for each deficiency will be completed. 8/8/22	,	
	3.1-19(b)					
K 0363 SS=E Bldg. 01	than required enciexits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containir combustible mate hardware. Roller I	corridor openings in other losures of vertical openings, is areas resist the passage made of 1 3/4 inch awood or other material ing fire for at least 20 fully sprinklered smoke expensive only required to resist the expensive confunction of the corridor doors and doors in the flammable or reals have positive latching atches are prohibited by these requirements do not				
	apply to auxiliary signammable or come Clearance between covering is not extended with a signamulation of the door closed with a closing of the door release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.4 frames shall be la	spaces that do not contain bustible material. In bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping hen a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors are permitted. Door beled and made of steel or compliance with 8.3,				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLI	
		155412	B. Wl	ING		07/19/	2022
	PROVIDER OR SUPPLIER	RID LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	allowed per 8.3. In there are no restri resistance of glas assemblies.	fire window assemblies are in sprinklered compartments actions in area or fire is or frames in window Parts 403, 418, 460, 482,					
	Show in REMARA fire protection rati devices, etc. Based on observation failed to ensure 4 of impediment to closs frame and would reserved.		K 0	363	K- 363- Corridor doors - what corrective action(s) will be accomplished for tho residents found to have been	se	08/08/2022
	frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include:				affected by the deficient practice; Maintenance director has insta a magnetic door holder on bed salon door that will disengage	auty	
	Director during a to p.m. to 2:20 p.m. or noted for corridor of a. the Salon door w position with a whe b. the door to reside Room 501 were pro with a waste basket	as propped in the fully open beled meal tray table. ent sleeping Room 109 and opped in the fully open position placed on the floor.			when tripped by the fire syster All other doors that were propopen are no longer being propopen. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will	ped oped nt d	
	resident sleeping R that the foot of the swing of the corridor allow the corridor of Maintenance Direct the bed closer to the the door to close by	tor tried to push the head of e wall to allow more space for at the bed couldn't be moved the corridor door to close and frame.			be taken; All residents have the potential be affected by the deficient practice - what measures will be printo place and what systemic changes will be made to ensure that the deficient practice does not recur; education was given to educat staff on not propping doors open staff on not propping doors on the deficient practice does not recur;	out C	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		<u>01</u>	COMPL	
		155412	B. WIN	G		07/19/	2022
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY		937 FR	DDRESS, CITY, STATE, ZIP COD Y RD WOOD, IN 46142		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P.	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the aforementioned impediment to closi frame and would no This finding was rev	aintenance Director agreed corridor doors each had an ng and latching into the door of resist the passage of smoke. viewed with the Administrator e Director during the exit			with any unapproved type of device. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, Facility management team will ensure all doors are free from unapproved door props keepir doors opened. Any doors four be propped open will have the prop removed immediately. - by what date the system changes for each deficiency will be completed. 8/8/22	ng nd to door	
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall 1/2-hour fire resist barriers shall be positive atrium wall. Smoke in duct penetration systems where an is installed for smoth to the smoke barrier 19.3.7.3, 8.6.7.1(1) Describe any mechants and the smoke barrier system in REMAR Based on observation failed to ensure 1 of protected to maintain smoke barrier. LSC smoke barriers to be with LSC Section 8	pall be constructed to a sance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.) hanical smoke control	K 03	72	K- 372- Smoke barrier - what corrective action(s will be accomplished for those residents found to have been affected by the deficient practice; Maintenance director installed	se 1	08/08/2022

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURV COMPLETED 07/19/202)
	PROVIDER OR SUPPLIEF	D LIVING COMMUNITY	937 FF	ADDRESS, CITY, STATE, ZIP CO RY RD NWOOD, IN 46142	D	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF could affect over 20 the vicinity of the c Findings include: Based on observation Director during a to p.m. to 2:20 p.m. or surrounding a one i penetrated the smol suspended ceiling a Room 505 was not interview at the tim Maintenance agreed surrounding the cor passage of smoke.	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Oresidents, staff and visitors in orridor door set by Room 505. The property of the facility from 12:45 In 07/19/22, the annular space Inch in diameter conduit which the barrier wall above the bove the corridor door set by firestopped. Based on In of the observations, the	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) appropriate fire rated ca inch diameter conduit he smoke barrier wall above corridor doors in the attiture of the potential to affected by the same diameter practice will be identified what corrective action (be taken; Residents living on 500 the potential to be affected deficient practice - what measures with into place and what system that the deficient practice does not recurred that the deficient will not recurred that the deficient will not recurred the monitored to endeficient practice has the second that deficient practice has the second that the second that deficient practice has the second that t	ulk in the 1 ble in the e the 505 c. ts be efficient ed and s) will hall have ed by the II be put stemic o nt r; illed int practice on(s) sure the not o POC) of onstrates as been cur. eystemic iency	(X5) MPLETION DATE
K 0511 SS=D Bldg. 01						

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Event ID:

ULTN21 Facility ID: 000509

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		A. Bl	A. BUILDING <u>01</u> CC			SURVEY LETED /2022		
		ROVIDER OR SUPPLIER	D LIVING COMMUNITY		937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ίΤΕ	(X5) COMPLETION DATE
		complies with NFF Code. Existing ins service provided in 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 1 of resident sleeping Research accordance with LS Electric Code, 2011 receptacles shall be terminals are not extended to the existence of the observation of the o	9.1.1, 9.1.2 on and interview, the facility Fover 4 electrical outlets in oom 112 were protected in C 19.5.1.1. NFPA 70, National Edition, Article 406.5, states enclosed so that live wiring posed to contact. This ould affect one resident and	K 0	511	K- 511- - what corrective action(swill be accomplished for tho residents found to have been affected by the deficient practice; Maintenance director replaced cracked outlet covers. All outle covers in facility were audited ensure that no others were cracked or missing and replace necessary - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential be affected by the deficient practice - what measures will be printo place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance director will ensure that all outlet covers are in plate and intact. - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, A TELS task was created to remind maintenance directors.	se n d all et to ced if nt d I ure cece	08/08/2022

PRINTED: 08/17/2022

EPARTMENT OF HEALTH AND HUN	FORM APPROVED			
ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) M			JLTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	TILDING <u>01</u>	COMPLETED
	155412	B. WING		07/19/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF FROVIDER OR SUFFLIER		937 FRY RD		
	DILIVING COMMUNITY		CDEENIMOOD IN 46142	

GREEN	WOOD HEALTH AND LIVING COMMUNITY	GREE	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			
			annually to audit all outlets to ensure proper covers are place by what date the systemic changes for each deficiency will be completed. 8/8/22				
⟨ 0711 ⟨ SS=F │	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required	K 0711	K-711- - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Maintenance director ensured that relocation of wheeled equipment during an emergency is addressed in the emergency disaster preparedness manual and that staff have been educated properly. - how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will	08/08/2022			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION (X3) DATE SURVE		/EY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED)	
		155412	B. W	ING		07/19/202	2	
		ı		STDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEI	₹		937 FR				
GREENWOOD HEALTH AND LIVING COMMUNITY								
GILLINVOOD HEALTH AND LIVING COMMONITY				GREENWOOD, IN 46142				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	MPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	width shall be permitted for wheeled equipment,				be taken;			
	*	the following conditions are			All residents have the potentia	al to		
	met:			be affected by the deficient				
		uipment does not reduce the			practice.			
		corridor width to less than 60			- what measures will be p			
	inches.	C C 1 1			into place and what systemic	-		
		occupancy fire safety plan and			changes will be made to			
	0.0	ldress the relocation of the			ensure that the deficient			
		during a fire or similar			practice does not recur;	, that		
	emergency.	aipment is limited to the			Staff have been educated on			
	following:	inplinent is infinited to the			to do with wheeled equipment			
	_	and corts in use			the hallways during an emerg and that all items but be move	-		
i. Equipment in use and carts in us					to not block the means of egre			
ii. Medical emergency equipment not in use iii. Patient lift and transport equipment					- how the corrective	755		
This deficient practice could affect all occupants.				action(s) will be monitored to	,			
	This deficient practice could affect all occupants.				ensure the deficient practice			
	Findings include:				will not recur,			
T munige menuel					Staff will be educated annuall	/ on		
Based on review of		"Emergency Disaster			proper procedures to ensure			
		al" documentation dated			means of egress during a fire			
	_	Administrator and the			similar emergency and to kee			
	Maintenance Assis	tant during record review from			means of egress clear for eas			
	8:50 a.m. to 12:50	p.m. on 08/10/21, the written fire			transport and movement of			
		facility did not address the			residents and staff during an			
	relocation of wheel	ed equipment during a fire or			emergency			
		Based on interview at the time			- by what date the syster	nic		
		inistrator and the Maintenance			changes for each deficiency			
	Assistant during red	cord review from 8:50 a.m. to			will be completed. 8/8/22			
	_	0/21, agreed the written fire						
		address the relocation of						
		during a fire or similar						
		on observations with the						
		tor during the initial walk						
	_	ity from 8:40 a.m. to 8:48 a.m.						
	· ·	er lift was stored in the corridor						
		eping Rooms 108, 110, 205,						
		and 507. A wheelchair was						
		or outside Room 112, 404, 408						
	and 410. Two 32 g	allon wheeled carts were also						

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		IDENTIFICATION NUMBER 155412	A. BU	BUILDING 01 WING			COMPLETED 07/19/2022	
	ROVIDER OR SUPPLIER	D LIVING COMMUNITY		937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD WOOD, IN 46142			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	wheeled plastic thre isolation supplies we corridor wall outside A crash cart was sto resident sleeping Rostand for a blood prothe corridor outside Based on observation Director during a top.m. to 2:20 p.m. on equipment observed during the initial was still stored in the conthe time of the observed the aforementioned.	r outside Room 506. A e drawer chest of drawers for as stored up against the e resident sleeping Room 505. red in the corridor outside soms 207 and 416. A wheeled essure cuff was also stored in resident sleeping Room 403. ons with the Maintenance our of the facility from 12:45 o7/19/22, all wheeled being stored in the corridor lk through of the facility was rridor. Based on interview at rvations, the Maintenance seled equipment was stored in means of egress. Viewed with the Administrator e Director during the exit						
K 0712 SS=F Bldg. 01	alarm signal and s conditions. Fire dri and unexpected tir conditions, at least The staff is familia aware that drills ar routine. Where dri 9:00 PM and 6:00 announcement maduible alarms. 19.7.1.4 through 1	t quarterly on each shift. r with procedures and is the part of established tills are conducted between AM, a coded by be used instead of	K 0'	712	K- 712- Fire drills (missing fire		08/08/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155412 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 937 FRY RD GREENWOOD HEALTH AND LIVING COMMUNITY GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to document quarterly fire drills on third drill) (Documentation) shift for 1 of 4 quarters. LSC Section 19.7.1.6 what corrective action(s) requires drills to be conducted quarterly on each will be accomplished for those shift under varied conditions. This deficient residents found to have been practice affects all residents, staff and visitors. affected by the deficient practice; Findings include: Missing fire drill was found and has been included in the POC Based on review of "Fire Drill Report" documentation documentation with the Administrator and the how other residents Maintenance Director during record review from having the potential to be 8:50 a.m. to 12:25 p.m. on 07/19/22, documentation affected by the same deficient of a third shift fire drill or staff training practice will be identified and documentation on fire drill procedures on the third what corrective action(s) will shift in the fourth quarter (October, November, be taken; December) 2021 was not available for review. All residents have the potential to Based on interview at the time of record review. be affected by the deficient the Administrator and the Maintenance Director practice. stated the facility operates three shifts per day what measures will be put and agreed documentation of a fire drill or staff into place and what systemic training on fire drill procedures for the third shift changes will be made to in the fourth quarter 2021 was not available for ensure that the deficient review. practice does not recur: Maintenance director will ensure This finding was reviewed with the Administrator that fire drills are conducted per and the Maintenance Director during the exit policy and documentation is kept conference. in the maintenance binder. how the corrective 3.1-19(b) action(s) will be monitored to ensure the deficient practice will not recur. Administrator will monitor Maintenance binder monthly during QA meetings to ensure that proper documentation is in place for all future fire drills. by what date the systemic changes for each deficiency

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will be completed. 8/8/22

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/19/2022
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZIP COD RY RD NWOOD, IN 46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0920 SS=D Bldg. 01	Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qual the conditions of 1 the patient care vi- non-PCREE (e.g., except in long-terre do not use PCREE meet UL 1363A or for non-PCREE in (outside of vicinity non-patient care re- other UL standard used with general cords are not used wiring of a structur temporarily are re- completion of the installed and meet 10.2.3.6 (NFPA 99 (NFPA 70), 590.3(Based on observation failed to ensure 1 of power strips were n fixed wiring. LSC comply with Section electrical wiring and NFPA 70, National NFPA 70, Article 4 specifically permitte shall not be used as a structure. LSC Sec	ent - Power Cords and ent - Power Strips in continuous enterties that have been elified personnel and meet 0.2.3.6. Power strips in conity may not be used for personal electronics), ent care resident rooms that E. Power strips for PCREE ent UL 60601-1. Power strips the patient care rooms enterties meet enterties. All power strips are precautions. Extension enterties as a substitute for fixed enterties enterties enterties enterties. Extension cords used enterties enterties enterties enterties. Extension cords including enterties ente	K 0920	K- 920- what corrective action(s) will be accomplishe for those residents found to have been affected by the deficient practice; Maintenance director affixed approved power strip to the waper Life Safety directors instructions in order to make it compliant. how other residents having the potential to be	all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155412 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 937 FRY RD GREENWOOD HEALTH AND LIVING COMMUNITY GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE safety shall be designed, installed and approved affected by the same deficient in accordance with all applicable NFPA standards. practice will be identified and NFPA 99, Standard for Health Care Facilities, 2012 what corrective action(s) will edition, defines patient care areas as any portion be taken; of a health care facility wherein patients are All residents have the potential to intended to be examined or treated. Patient care be affected by the deficient vicinity is defined as a space, within a location practice. intended for the examination and treatment of what measures will be put patients, extending 6 ft (1.8 m) beyond the normal into place and what systemic location of the bed, chair, table, treadmill, or other changes will be made to device that supports the patient during ensure that the deficient examination and treatment. A patient care vicinity practice does not recur: extends vertically to 7 ft 6 in. (2.3 m) above the Maintenance director ensure that floor. NFPA 99, Section 10.4.2.3 states household any other power strip currently in or office appliances not commonly equipped with use in the facility is affixed to the grounding conductors in their power cords shall wall to meet code and that all be permitted provided they are not located within power strips meet proper industry the patient care vicinity. This deficient practice standard to be used in a could affect 2 residents in Room 213. healthcare facility. how the corrective Findings include: action(s) will be monitored to ensure the deficient practice Based on observations with the Maintenance will not recur. Director during a tour of the facility from 12:45 A TELS task was created to p.m. to 2:20 p.m. on 07/19/22, a fan and the remind maintenance director or resident's laptop computer were plugged into a affiliate to monitor all resident power strip placed on the floor underneath the rooms monthly to ensure proper resident bed nearest the corridor door in Room adherence with policy regarding 213. The UL listing of the power strip could not power strips/extension cords used be determined. Based on interview at the time of in resident room. the observations, the Maintenance Director by what date the systemic agreed non-PCREE were plugged into a power changes for each deficiency strip in the patient care vicinity in the will be completed. 8/8/22 aforementioned resident sleeping room and agreed a power strip was being used as a substitute for fixed wiring in the resident room. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.

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STATEMEN	IT OF DEFICIENCIES	CIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155412	B. WING			07/19/2022		
NAME OF PROVIDER OR SUPPLIER GREENWOOD HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID	SUMMARY	MMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)		TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				DATE		
	3.1-19(b)							

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