STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155188	A. BUILDING -- B. WING	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

(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: 01/02/25 Facility Number: 000099 Provider Number: 155188 AIM Number: 100291140 At this Emergency Preparedness survey, Greenfield 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 163 certified beds. At the time of the survey, the census was 110. Quality Review completed on 01/07/25	E 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices.	
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: 01/02/25 Facility Number: 000099 Provider Number: 155188 AIM Number: 100291140 At this Life Safety Code survey, Greenfield	K 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Clark	Executive Director	01/16/2025

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 (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 163 and had a census of 110 at the time of this visit. 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 01/07/25		paper compliance regarding alleged deficient practices.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and	K 0361	K361 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The corridor door to the therapy room has now been equipped with a positive latching mechanism. 2. How will other residents having the same potential to be affected	01/17/2025

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	(b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:00 p.m. on 01/02/25, the corridor door to the Therapy Room was not equipped with a positive latching mechanism to latch the door into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the Therapy Room was not equipped with a positive latching device to latch the door into the door frame. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		by the alleged deficient practice be identified and what corrective action will be taken? All residents, staff, and visitors in the vicinity of the therapy room have the potential to be affected by this alleged deficiency. The corridor door to the therapy room has been fixed and has a latching mechanism to latch the door into the door frame. 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 Maintenance Director and/or Designee will perform weekly checks to ensure the therapy door has a positive latching mechanism. Maintenance Director/assistant were educated on doors resisting the passage of smoke by having proper latching mechanism. 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 routinely inspected and issues documented accordingly 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? 1/17/2025	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA	K 0761	K761 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The annual inspection was completed for the oxygen storage areas located on the 100, 200, and 300 halls. 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. An annual fire door inspection was completed on the remaining fire doors and documented in TELS. 3. What measures will be put into place or systemic changes will be	01/17/2025

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	80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire/Smoke Door Inspection" documentation dated 09/09/24 with the Executive Director and the Maintenance Director during		made to ensure that the alleged deficient practice does not occur? Fire doors are to be inspected annually and documented in TELS. Maintenance director and assistant have been educated on timeliness of inspecting the fire doors and completing items timely via the TELS system. Divisional Facilities Manager added oxygen door inspections to the TELS system. 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 and issues documented accordingly 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. 5. By what date will systemic changes be completed? 1/17/2025	

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	record review from 9:15 a.m. to 12:50 p.m. on 01/02/25, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. The annual inspection documentation dated 09/09/24 did not include fire door locations at indoor oxygen storage and transfilling rooms. Based on interview at the time of record review, the Maintenance Director stated the facility has indoor oxygen storage areas and agreed annual fire door inspection documentation for these areas within the most recent twelve month period was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:00 p.m. on 01/02/25, the corridor door to the 100 Hall, 200 Hall and 300 Hall oxygen storage and transfilling rooms each had a 90-minute fire resistance rating label affixed to the hinge side of the door. Two liquid oxygen containers and twelve 'E' type oxygen cylinders were stored in the 100 Hall oxygen storage and transfilling room. Five liquid oxygen containers and eight 'E' type oxygen cylinders were stored in the 200 Hall oxygen storage and transfilling room One liquid oxygen container and seven 'E' type oxygen cylinders were stored in the 300 Hall oxygen storage and transfilling room. Based on interview at the time of the observations, the Maintenance Director agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)			

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K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Based on observation and interview, the facility failed to protect 2 of over 75 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect 2 residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:25 p.m. to 4:00 p.m. on 01/02/25, one liquid oxygen container was stored and in use in resident sleeping Room 117. One liquid oxygen container was also stored and in use in resident sleeping Room 215. Room 117 and Room 215 were not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the rooms was not self-closing or automatic closing but each door was equipped with a 90-minute fire resistance rating label affixed to the door. Based on interview at the time of the observations, the Executive Director and the Maintenance Director	K 0930	K930 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The liquid oxygen containers were immediately removed from room 117 and 215. 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, staff or visitors were affected by this deficient practice. The liquid oxygen containers were removed from the room and maintenance checked all resident rooms to ensure no liquid oxygen containers were in rooms. 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 Director/designee were educated on self-closing or automatic-closing doors to ensure fire barriers are in place. Nursing staff was educated on using high-flow concentrators in place of liquid oxygen containers for	01/17/2025

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	agreed liquid oxygen containers were stored and in use in the rooms and each room was not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Executive Director and the Maintenance Director during the exit conference.		residents with high liter output. 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 rooms are inspected weekly to ensure no liquid oxygen usage is present in resident rooms. 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. 5. By what date will systemic changes be completed? 1/17/2025	