STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155193	A. BUILDING -- B. WING	07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTHCARE CENTER	377 WESTRIDGE BLVD GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/24/23 Facility Number: 000101 Provider Number: 155193 AIM Number: 100291290 At this Emergency Preparedness survey, Greenwood Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 185 certified beds. At the time of the survey, the census was 165. Quality Review completed on 07/25/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/24/23 Facility Number: 000101 Provider Number: 155193 AIM Number: 100291290 At this Life Safety Code survey, Greenwood	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda Turner, HFA	Executive Director	08/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in Room 339. The facility has battery operated smoke detectors installed in all resident sleeping rooms except Room 339. Resident sleeping Rooms 211, 212, 213, 214, 217, 218, 219, 220, 223, 224 and 233 were being used as vent unit bed rooms with a total of 21 vent unit bed locations in the facility. The facility has a capacity of 185 and had a census of 165 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 07/25/23			
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility	K 0300	**K300 – Protection Other**	08/10/2023

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	failed to replace battery operated smoke alarms installed in 3 of over 90 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 4:00 p.m. on 07/24/23, manufacturer's documentation affixed to the First Alert Model SA340 battery operated smoke alarm installed on the ceiling in resident sleeping Room 106, 109 and 319 each indicated it was manufactured 02/07/12. The manufacturer's documentation also stated "replace unit within 10 years of installation date" but the installation date was not recorded on each of the three smoke alarms. Sleeping Room 300 also had a First Alert Model SA340 battery operated smoke alarm installed on the ceiling in the room but manufacturer's documentation affixed to the smoke alarm indicated it was manufactured 08/15/19. Based on interview at the time of the observations, the Maintenance Director stated some smoke alarms in resident sleeping rooms have been changed out within the most recent ten year period but agreed the smoke alarms installed in the aforementioned three resident sleeping rooms were each greater than 10		It is the policy of this facility to provide functional battery operated smoke detectors. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by this alleged deficiency. Battery Operated smoke detectors are checked weekly and replaced if not functioning properly. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected or had the potential to be. New battery operated smoke detectors were ordered and all were replaced with date of installation marked on the detectors. 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 will continue to check the battery operated smoke detectors monthly and replace if not functioning properly.	

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	years old. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance was inserviced on dating detectors at time of installation and the need to replace every 10 years. 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 the smoke detectors are checked weekly and replaced if not properly functioning. 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? 8/10/2023	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.			

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	Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 14 hazardous areas such as trash collection rooms (exceeding 64 gallons) was separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 3 staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 4:00 p.m. on 07/24/23, the corridor door to the kitchen dish washing area was held in the fully open position with a magnetic hold open device set to release with fire alarm system activation,	K 0321	**K321 - Enclosures** It is the policy of this facility to ensure self-closing doors close and latch appropriately. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected. No residents have the potential to be affected by the door in the kitchen dish room.	08/10/2023

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	latching hardware and a self closing device but the door failed to self close and latch into the door frame when tested to close multiple times. The kitchen contained over two 32 gallon capacity trash receptacles and one 14 cubic foot (104 gallon) trash receptacle. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the kitchen by the dishwashing area would not fully self close and latch into the door frame and agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents or visitors are allowed in this area. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? All self-closure doors were audited to ensure they latch appropriately. Doors are checked monthly to ensure they close accordingly. Doors will continue to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on how to properly check self-closure doors for appropriate closure. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that doors are inspected monthly. Maintenance Supervisor and will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of	

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			the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 8/10/2023	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with 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 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to maintain the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and	K 0324	**K324 – Cooking Facilities** It is the policy of this facility to have the required drip pans in the proper location of the range hood system.	08/10/2023

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	Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect over three staff and visitors in the kitchen. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 4:00 p.m. on 07/24/23, two of two designated locations underneath the kitchen range hood system drip tray was missing its enclosed metal container for grease to drain into. Each designated location for a grease container had a one half inch in diameter hole in the drip tray beneath the system filters but no metal container was in place. Based on interview at the time of the observations, the Maintenance Director agreed the two designated locations underneath the kitchen range hood system drip tray was missing its enclosed metal container for grease to drain into. This finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected. The drip pans were being cleaned and were replaced accordingly. 2. How will other residents having the same potential to be affected by the alleged deficient practice be identified and what corrective action will be taken? No residents had the potential to be affected by this alleged deficiency. The drip pans were being cleaned and were replaced accordingly. 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/Designee will check drip pan placement weekly x4 weeks then monthly x5 months. Maintenance and dietary staff inserviced to immediately replace drip pans after cleaning. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not	

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			occur? The Maintenance Supervisor and/or Designee will ensure that drip pans are in place weekly x4 weeks then monthly x5 months. 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? 8/10/23	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed			

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	6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction for 1 of 1 ceiling's in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 4:00 p.m. on 07/24/23, the ceiling mounted sprinkler located in the restroom by the Activities Room was missing its escutcheon. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned sprinkler location was missing its escutcheon. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0351	**K 351 – Sprinkler System Installation** It is the policy of this facility to have escutcheon rings around sprinkler heads. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by this alleged deficient practice. An escutcheon ring was installed on the identified sprinkler head. 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 other residents had the potential to be affected. All sprinkler heads were inspected and there were no other missing escutcheon rings were identified 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not	08/10/2023

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			occur? Escutcheons will be replaced accordingly. No other missing escutcheons were found. Maintenance has been educated on appropriate inspection of mounted fire sprinklers. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that sprinkler heads are inspected monthly. Maintenance Supervisor will report findings to the QA/QAPI committee monthly X 6 months. If 100 % compliance or greater has not been achieved by the end of the 6 months, then the monitoring will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 8/10/23	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment			

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	(PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of	K 0920	**K920 Electrical Equipment – Extension Cords** It is the policy of this facility that Power Cords / Extension cords will not be utilized in resident rooms. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by this alleged deficiency. Resident was already informed the power strip was not allowed. It was sitting on bedside table for resident to give	08/10/2023

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	patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect two residents, staff and visitors in resident sleeping Room 207. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:05 p.m. to 4:00 p.m. on 07/24/23, a power strip was plugged into the wall in the patient care vicinity nearest the resident bed in Room 207. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Maintenance Director stated nothing was plugged into the power strip but agreed a power strip was being used in the patient care vicinity at the aforementioned location. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		to family. 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? An audit was completed of all resident rooms and no other power strips were found. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Maintenance Director / Designee will randomly check 5 rooms for power strips / extension cords weekly x4 weeks & then monthly x 5 months. Checking rooms for power strips / extension cords have been added to the leadership teams Angel Rounds check lists. Maintenance has been inserviced on power strips / extension cords. 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 free of power strips / extension cords monthly. Maintenance Supervisor and will report findings to the QA/QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING 01 B. WING	07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			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? 8/10/23	