	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED 1B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	î î	JILDING	ONSTRUCTION	LETED	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 200 GREEN MEADOWS DR GREENFIELD, IN 46140				
(X4) ID PREFIX TAG E 0000	(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 BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 08/2 Facility Number: 0 Provider Number: 100 At this Emergency Greenfield Healthc compliance with E Requirements for N Participating Provi 483.73 The facility has 16 the survey, the cen	4/22 000099 155188 0291140 Preparedness survey, are Center was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR 3 certified beds. At the time of	EO	000	Preparation or execution of the plan of correction does not a constitute admission or agree of provider of the truth of the alleged or conclusions set for the Statement of Deficiencie The Plan of Correction is preand executed solely because required by the position of For and State Law. The Plan of Correction is submitted in orrespond to the allegation of noncompliance cited during facility's Life Safety Code with Emergency Preparedness S Please accept this plan of correction as the provider's credible allegation of compliance to be considered a desk review with paper compliance to be considered establishing that the provider substantial compliance.	ement facts rth on s. epared e it is ederal der to the th urvey. ance. juests	
К 0000 Bldg. 01	Licensure Survey v	000099	К 0	000	Preparation or execution of t plan of correction does not constitute admission or agre of provider of the truth of the alleged or conclusions set fo the Statement of Deficiencie The Plan of Correction is pre and executed solely because required by the position of Fo	ement facts orth on s. epared e it is	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 10/04/2022

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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPL A. BUILDING B. WING	ple construction ng <u>01</u>		(X3) DATE SURVEY COMPLETED 08/24/2022	
NAME OF	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP COD GREEN MEADOWS DR			
GREEN	FIELD HEALTHCA	RE CENTER		EENFIELD, IN 46140			
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	ION D BE	(X5) COMPLETIO	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG			DATE	
	AIM Number: 10	0291140		and State Law. The Plan	of		
	Healthcare Center with Requirements Medicare/Medicai Life Safety from F National Fire Proto Life Safety Code ( Health Care Occup This one-story fac equipment area wa (000) construction has a fire alarm sy the corridors, space battery-operated st sleeping rooms. T and had a census of All areas where re were sprinkled and services were sprin sheds which were	Code survey, Greenfield was found not in compliance is for Participation in d, 42 CFR Subpart 483.90(a), fire and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing bancies and 410 IAC 16.2. ility with a second story as determined to be of Type V and fully sprinkled. The facility stem with smoke detection in es open to the corridors, and moke detectors in all resident the facility has a capacity of 163 of 126 at the time of this visit. sidents have customary access all areas providing facility the except for four outside used for storage.		Correction is submitted in respond to the allegation of noncompliance cited durin facility's Life Safety Code Emergency Preparedness Please accept this plan of correction as the provider credible allegation of com The provider respectfully n a desk review with paper compliance to be consider establishing that the provi substantial compliance.	of g the with Survey. s bliance. equests red in		
< 0100 SS=E Bldg. 01	NFPA 101 General Require General Require List in the REMA Section 18.1 and that are not addr K-tags, but are d along with the ap	ments - Other ments - Other RKS section any LSC 19.1 General Requirements essed by the provided eficient. This information, plicable Life Safety Code or citation, should be included					
	Based on observat failed to maintain	ion and interview, the facility latching hardware on 1 of 2 rs per 4.6.12.3. LSC 4.6.12.3	K 0100	<b>K100</b> It is the policy of this facil provide latching hardware	-	09/12/202	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 08/24/2022	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 200 GREEN MEADOWS DR GREENFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY OF requires existing If the public if not re- either maintained practice could affer Findings include: Based on observat with the Maintena 12:45 p.m. and 4:4 doors near the Phy Hall did not positi during the time of doors self-closed a mild pressure was broke free from th engaging the open Maintenance Dire- missing, and the d adjusted to latch p	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION if e safety features obvious to equired by the Code, shall be or removed. This deficient ext 25 residents in the TCU hall. ions during a tour of the facility nce Director 08/24/22 between 45 p.m., the set of barrier double vsicians Lounge on the TCU vely latch. Based on interview observations, the double barrier and appeared to latch but when applied to one of the doors, it e latch and reopened, without ing hardware. The ctor stated that a screw was oor set would need to be	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) doors. 1. What corrective Action will accomplished for those residu found to have been affected b alleged deficient practice? Facility has installed new lator mechanism on the double do near the physicians lounge of TCU hallway. 2. How will other residents have the same potential to be affected by the alleged deficient practice be identified and what correct action will be taken? No residents or visitors were affected by this alleged defici 3. What measures will be pu place or systemic changes will made to ensure that the alleged deficient practice does not occ Doors are to be checked moded to ensure they close accordingly. Doors will contined be checked monthly with repare replacements done accordinged Maintenance has been education on how to properly check fired doors for appropriate closure 4. How will the corrective action be monitored to ensure the all deficient practice will not occut The Maintenance Supervisor and/or Designee will ensure the doors are inspected monthly. Maintenance Supervisor and report findings to the QA/QAF committee monthly X 6 monthl 100 % compliance or greater not been achieved by the end	ATE COMP DA	XS) LETI

(EACH DEFICIEN <u>REGULATORY OF</u> PA 101 ress Doors ess Doors ors in a require equipped with uires the use of ess side unles cial locking arr NICAL NEEDS CKING ere special loc	RE CENTER STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	200 GF	01 ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR NFIELD, IN 46140 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Will continue until this threshold has been reached. 5. By what date will systemic changes be completed? 9/12/2022	DATE
PA 101 ess Doors ors in a require equipped with uires the use of ess side unles cial locking an NICAL NEEDS CKING ere special loc	RE CENTER STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ed means of egress shall not a latch or a lock that of a tool or key from the is using one of the following rangements: S OR SECURITY THREAT	200 GF GREEI ID PREFIX	REEN MEADOWS DR NFIELD, IN 46140 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) will continue until this threshold has been reached. 5. By what date will systemic changes be completed?	E COMPLETION DATE
SUMMARY (EACH DEFICIEN REGULATORY OF PA 101 ess Doors prs in a require equipped with uires the use of ess side unles cial locking an NICAL NEEDS CKING ere special loc	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ed means of egress shall not a latch or a lock that of a tool or key from the is using one of the following rangements: S OR SECURITY THREAT	GREEI ID PREFIX	NFIELD, IN 46140  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  will continue until this threshold has been reached. 5. By what date will systemic changes be completed?	E COMPLETION DATE
(EACH DEFICIEN <u>REGULATORY OF</u> PA 101 ress Doors ess Doors ors in a require equipped with uires the use of ess side unles cial locking arr NICAL NEEDS CKING ere special loc	ed means of egress shall not a latch or a lock that of a tool or key from the se using one of the following rangements: S OR SECURITY THREAT	PREFIX	<ul> <li>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</li> <li>will continue until this threshold has been reached.</li> <li>5. By what date will systemic changes be completed?</li> </ul>	E COMPLETION DATE
PA 101 ress Doors ress Doors ors in a require equipped with uires the use of ess side unles ricial locking an NICAL NEEDS CKING ere special loc	ed means of egress shall not a latch or a lock that of a tool or key from the is using one of the following rangements: S OR SECURITY THREAT		<ul> <li>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</li> <li>will continue until this threshold has been reached.</li> <li>5. By what date will systemic changes be completed?</li> </ul>	DATE
PA 101 ess Doors ors in a require equipped with uires the use o ess side unles cial locking an NICAL NEEDS CKING ere special loc	ed means of egress shall not a latch or a lock that of a tool or key from the is using one of the following rangements: S OR SECURITY THREAT	TAG	will continue until this threshold has been reached. 5. By what date will systemic changes be completed?	DATE
ess Doors ess Doors ors in a require equipped with uires the use of ess side unles icial locking an NICAL NEEDS CKING ere special loc	a latch or a lock that of a tool or key from the is using one of the following rangements: S OR SECURITY THREAT		has been reached. 5. By what date will systemic changes be completed?	
ess Doors ess Doors ors in a require equipped with uires the use of ess side unles icial locking an NICAL NEEDS CKING ere special loc	a latch or a lock that of a tool or key from the is using one of the following rangements: S OR SECURITY THREAT			
d, only one loo mitted on each made for the ra- remote contro is or keys carr er such reliable f at all times. 2.2.2.5.1, 18.2 2.2.2.6 ECIAL NEEDS RANGEMENT ere special loc ety needs of th Clinical or Sec being met. In ctrical locks that ease upon loss ding is protect omatic sprinkle ice is protected	eeds of the patient are cking device shall be n door and provisions shall apid removal of occupants of of locks; keying of all ried by staff at all times; or e means available to the 2.2.2.6, 19.2.2.2.5.1, CLOCKING S cking arrangements for the ne patient are used, all of curity Locking requirements addition, the locks must be at fail safely so as to s of power to the device; the ted by a supervised er system and the locked d by a complete smoke			
	hitted on each ade for the r emote control or keys carr r such reliabl at all times. .2.2.5.1, 18.2 .2.2.6 CIAL NEEDS ANGEMENT re special loc ay needs of th Clinical or Se being met. In rical locks th ase upon loss ing is protect matic sprinkle e is protected ction system a attended loc	2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 2.2.6 CIAL NEEDS LOCKING ANGEMENTS re special locking arrangements for the ty needs of the patient are used, all of Clinical or Security Locking requirements being met. In addition, the locks must be rical locks that fail safely so as to use upon loss of power to the device; the ing is protected by a supervised matic sprinkler system and the locked e is protected by a complete smoke ction system (or is constantly monitored a attended location within the locked	hitted on each door and provisions shall hade for the rapid removal of occupants emote control of locks; keying of all s or keys carried by staff at all times; or r such reliable means available to the at all times. 2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 2.2.6 CIAL NEEDS LOCKING ANGEMENTS re special locking arrangements for the ty needs of the patient are used, all of Clinical or Security Locking requirements being met. In addition, the locks must be rical locks that fail safely so as to use upon loss of power to the device; the ing is protected by a supervised matic sprinkler system and the locked e is protected by a complete smoke ction system (or is constantly monitored a attended location within the locked	hitted on each door and provisions shall hade for the rapid removal of occupants emote control of locks; keying of all sor keys carried by staff at all times; or r such reliable means available to the at all times. 2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 2.2.6 CIAL NEEDS LOCKING ANGEMENTS re special locking arrangements for the ty needs of the patient are used, all of Clinical or Security Locking requirements being met. In addition, the locks must be rical locks that fail safely so as to use upon loss of power to the device; the ing is protected by a supervised matic sprinkler system and the locked e is protected by a complete smoke ction system (or is constantly monitored a attended location within the locked

STATEMENT OF DEFICIENC	ES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION <u>01</u>	(X3) DATE SURVEY COMPLETED 08/24/2022		
NAME OF PROVIDER OR SU		200 G	ET ADDRESS, CITY, STATE, ZIP COD GREEN MEADOWS DR EENFIELD, IN 46140			
· · ·	IARY STATEMENT OF DEFICIENCIE ICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO		
TAG REGULATO	RY OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
systems are upon activat 18.2.2.5.2, DELAYED-E ARRANGEM Approved, lis systems inst 7.2.1.6.1 sha assemblies as contents in b an approved detection sys automatic sp 18.2.2.2.4, 1 ACCESS-CO LOCKING A Access-Com installed in a be permitted 18.2.2.2.4, 1 ELEVATOR LOCKING A Elevator lobil accordance on door asse throughout b automatic fir approved, st system. 18.2.2.2.4, 1 I. Based on o failed to ensu accessible and deficient prac Brookshire H	19.2.2.2.5.2, TIA 12-4 GRESS LOCKING ENTS ted delayed-egress locking alled in accordance with Il be permitted on door erving low and ordinary hazard uildings protected throughout by supervised automatic fire tem or an approved, supervised rinkler system. 0.2.2.2.4 WTROLLED EGRESS RANGEMENTS rolled Egress Door assemblies coordance with 7.2.1.6.2 shall 0.2.2.2.4 LOBBY EXIT ACCESS RANGEMENTS y exit access door locking in with 7.2.1.6.3 shall be permitted mblies in buildings protected y an approved, supervised e detection system and an pervised automatic sprinkler 0.2.2.2.4 DOBSY EXIT ACCESS RANGEMENTS y exit access door locking in with 7.2.1.6.3 shall be permitted mblies in buildings protected y an approved, supervised e detection system and an pervised automatic sprinkler 0.2.2.2.4 DOBSY EXIT ACCESS RANGEMENTS y exit access door locking in with 7.2.1.6.3 shall be permitted mblies in buildings protected y an approved, supervised e detection system and an pervised automatic sprinkler	K 0222	K 222 It is the policy of this facility to provide exits at Egresses. 1. What corrective Action will be accomplished for those resided found to have been affected by alleged deficient practice? The facility received a proposa replace the door to the exit by	be nts y the Il to		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	A (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 08/24/2022	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD		
GREEN	FIELD HEALTHCA	RE CENTER		REEN MEADOWS DR ENFIELD, IN 46140		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC	
TAG		DR LSC IDENTIFYING INFORMATION nce Director 08/24/22 between	TAG	generator on the brookshire ha	DATE	
		45 p.m., the exit door on the		and was approved. Facility is ju		
	-	ear the Generator would not		waiting for new door to arrive a		
	open when easily	on the first try when tested. The		be installed. The code has bee		
	Surveyor, then the	Maintenance Director tried to		posted accordingly to the exit of	door	
	open the door, and	l the Maintenance Director was		from the corridor into the main		
		rable effort to open the exit		courtyard.		
		nance Director stated that there		2. How will other residents have	ving	
		rust which builds up on the door		the same potential to be affect		
	frame because it is	s not used often.		by the alleged deficient practic		
				be identified and what corrective	/e	
		cknowledged by the		action will be taken?		
		ctor at the time of discovery and		No residents were affected by		
	-	onference with the Maintenance		alleged deficiency. The code h		
		utive Director present at 5:30		been posted and a new door w	las	
	p.m.			purchased. No other areas identified during inspection.		
	2 Based on observ	vation and interview, the facility		3. What measures will be put in	nto	
		e means of egress through the		place or systemic changes will		
		readily accessible for residents		made to ensure that the allege		
	-	diagnosis requiring specialized		deficient practice does not occ		
		Doors within a required means		The exit door near the genera		
	of egress shall not	be equipped with a latch or		on the brookshire hallway and		
	lock that requires	the use of a tool or key from the		gate in the courtyard will be		
	U	otherwise permitted by LSC		inspected monthly to ensure th	e	
		locking arrangements shall be		door can open with ease and t		
	-	dance with 19.2.2.5.2. This		code is posted in the courtyard		
	-	could affect over 15, staff and		area. Staff educated as to whe	ere	
	visitors if needing	to exit the facility.		to find posted code.		
	Eindinge includes			4. How will the corrective actio		
	Findings include:			monitored to ensure the allege deficient practice will not occur		
	Based on observat	ions during a tour of the facility		The Maintenance Supervisor	•	
		nce Director 08/24/22 between		and/or Designee will ensure th	at	
		45 p.m., the exit door from the		code is posted monthly.		
	-	nain courtyard, was marked as a		Maintenance Supervisor will re	port	
		nagnetically locked and could be		findings to the QA/QAPI		
		g a four-digit code but the code		committee monthly X 6 months	s. If	
	was not posted at			100 % compliance or greater h not been achieved by the end	nas	

	R MEDICARE & MED	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
			· · ·			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155188	A. BUILDING B. WING	01	COMPLETED 08/24/2022	
		155186	B. WING		00/24/2022	
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP COD		
				REEN MEADOWS DR		
GREEN	FIELD HEALTHCA		GREET	NFIELD, IN 46140		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX	(EACH DEFICII	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP		
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	This finding was	acknowledged by the		the 6 months, then the moni	itoring	
	Maintenance Dire	ector at the time of discovery and		will continue until this thresh	old	
	again at the exit c	onference with the Maintenance		has been reached.		
	Director and Exec	cutive Director present at 5:30		5. By what date will system	ic	
	p.m.			changes be completed?		
	-			9/12/2022		
	3.1-19(b)					
< 0321	NFPA 101					
SS=E	Hazardous Area					
Bldg. 01	Hazardous Area					
Diug. 01						
		s are protected by a fire				
	-	hour fire resistance rating				
	•	e rated doors) or an				
		tinguishing system in				
		8.7.1 or 19.3.5.9. When the				
		atic fire extinguishing system				
		he areas shall be separated				
		es by smoke resisting				
		pors in accordance with 8.4.				
	Doors shall be s	•				
		g and permitted to have				
		-applied protective plates that				
		8 inches from the bottom of				
	the door.					
		or and zone locations of				
		s that are deficient in				
	REMARKS.	0				
	19.3.2.1, 19.3.5.	9				
	Area	Automatic Sprinkler				
	Separation	N/A				
	a. Boiler and Fu	el-Fired Heater Rooms				
	b. Laundries (lar	ger than 100 square feet)				
		enance, and Paint Shops				
		Rooms (exceeding 64				
	gallons)	· · · · ·				
	e. Trash Collect	ion Rooms				
	(exceeding 64 g					
		Storage Rooms/Spaces				
			1	i i i i i i i i i i i i i i i i i i i	1	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULT A. BUILI B. WING	DING	DNSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/24/2022	
	PROVIDER OR SUPPLIE		2	200 GF	ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR		
GREEN	FIELD HEALTHCA	RE CENTER	C	GREEN	NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ΛTE	(X5) COMPLETION DATE
	<ul> <li>(over 50 square f</li> <li>g. Laboratories (i</li> <li>Hazard - see K3:</li> <li>Based on observation failed to ensure the hazardous rooms visual failed to ensure the fame smoke comp</li> <li>Findings include:</li> <li>Based on observation with the Maintenan 12:45 p.m. and 4:4</li> <li>following hazardor requirements for p</li> <li>a) Resident Room square feet and coor supplies and was r</li> <li>b) The Unit Manage than 50 square feet paper, boxes, and c) Resident Room square feet and coor construction equips packle and other spackle and the frame.</li> <li>This finding was a Maintenance Direct again at the exit con space for the frame.</li> </ul>	feet) f classified as Severe 22) ion and interview, the facility e corridor doors to 3 of 3 were provided with a e which would cause the door to e and latch into the door frame. trice could affect 40 residents in artments. ions during a tour of the facility nce Director 08/24/22 between 15 p.m., the corridor doors to the us areas did not meet the rotection of a hazardous area: #301 which was larger than 50 ntained over 30 boxes of	K 032		<b>K 321</b> It is the policy of this facility to ensure self-closing devices an present on doors considered in hazardous rooms. 1. What corrective Action will accomplished for those reside found to have been affected to alleged deficient practice? Facility has installed self-close devices on doors identified in hazardous rooms. 2. How will other residents has the same potential to be affect by the alleged deficient practi be identified and what correct action will be taken? No residents or visitors are allowed in this area. The 3 do identified as hazardous rooms had self-closing devices insta by maintenance. All doors we checked to ensure there were other deficiencies. 3. What measures will be put place or systemic changes wi made to ensure that the alleg deficient practice does not oc Doors are checked monthly to ensure they close accordingly. Doors will contin to be checked monthly with repairs / replacements done accordingly. Maintenance has been educated on having self-closing devices on doors hazardous rooms.	re to be be ents by the sing aving aving aving aving aving aving ted ce ive bors s all lled re to s all lled re to s no into ll be ed cur? o	09/12/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: **Y3ES21** Facility ID: **000099** 

If continuation sheet Page 8 of 31

	R MEDICARE & MEDIC						1B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	A. BUILDING <u>01</u> COMPI				e survey leted 1 <b>/2022</b>
	PROVIDER OR SUPPLIE			200 GF	ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC DEFICIENCY)	ON DE PRIATE	(X5) COMPLETION DATE
	3.1-19(b)				4. How will the corrective a monitored to ensure the all deficient practice will not o The Maintenance Supervi and/or Designee will ensur doors are inspected month Maintenance Supervisor al report findings to the QA/C committee monthly X 6 mc 100 % compliance or great not been achieved by the e the 6 months, then the mon will continue until this threst has been reached. 5. By what date will system changes be completed? 9/12/2022	leged ccur? sor e that ly. nd will API nths. If ter has end of nitoring shold	
K 0351 SS=E Bldg. 01	by construction ty throughout by an sprinkler system 13, Standard for Systems. In Type I and II co protection measu substituted for sp areas where state sprinklers. In hospitals, sprin clothes closets of where the area o 6 square feet and the closet footprin						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 08/24/2022 155188 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 GREEN MEADOWS DR GREENFIELD HEALTHCARE CENTER GREENFIELD, IN 46140 (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 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) K 0351 Based on observation and interview, the facility K 351 09/12/2022 failed to maintain the ceiling construction in in 1. What corrective Action will be accordance with NFPA 13, Standard for the accomplished for those residents Installation of Sprinkler Systems. NFPA 13, 2010 found to have been affected by the edition, Section 6.2.7.1 states plates, escutcheons, alleged deficient practice? or other devices used to cover the annular space No residents were affected by this around a sprinkler shall be metallic, or shall be alleged deficiency. Sprinkler listed for use around a sprinkler. This deficient company contacted to install practice could affect staff and up to 2 staff and 12 missing escutcheons. residents. 2. How will other residents having the same potential to be affected Findings include: by the alleged deficient practice be identified and what corrective Based on observations during a tour of the facility action will be taken? with the Maintenance Director 08/24/22 between An audit was completed of all 12:45 p.m. and 4:45 p.m., (1) a Sprinkler Head mounted sprinklers inside/outside outside the main dining room exit, in the of the building to ensure overhang, was missing an escutcheon and did not compliance. No other missing completely cover the hole around the sprinkler. escutcheons were found. And (2) in the main dining room area, on the Maintenance has been educated second tier of the ceiling, 1 sprinkler head was on appropriate inspection of missing an escutcheon, and did not completely mounted fire sprinklers. cover the hole around the sprinkler. 3. What measures will be put into place or systemic changes will be This finding was acknowledged by the made to ensure that the alleged Maintenance Director at the time of discovery and deficient practice does not occur? again at the exit conference with the Maintenance Escutcheons will be replaced Director and Executive Director present at 5:30 accordingly. No other missing p.m. escutcheons were found. Maintenance has been educated 3.1-19(b) on appropriate inspection of mounted fire sprinklers. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? The Maintenance Supervisor and/or Designee will ensure that sprinklers are inspected monthly. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y3ES21 Facility ID: 000099 Page 10 of 31 If continuation sheet

10/04/2022

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	R MEDICARE & MEDI			CONCERNICE		MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		(X3) DATE SURVEY COMPLETED 08/24/2022	
	PROVIDER OR SUPPLIE		200 G	t address, city, state, zip cod GREEN MEADOWS DR ENFIELD, IN 46140		
( <b>V</b> 4) ID	SUMMADA	STATEMENT OF DEFICIENCIE	ID			(¥5)
(X4) ID PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E E	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				Maintenance Supervisor and report findings to the QA/QA committee monthly X 6 mon 100 % compliance or greate not been achieved by the er the 6 months, then the moni will continue until this thresh has been reached. 5. By what date will system changes be completed? 9/12/2022	NPI ths. If r has nd of toring old	
SS=F Bldg. 01	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testin Water-based Fire Records of syste inspection and te secure location a a) Date sprinkle b) Who provide c) Water system Provide in REMA coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 1. Based on record facility failed to m accordance with L automatic sprinkle and maintained in Standard for the In	RKS information on non-required or partial er system.	K 0353	K353 It is the facility policy to ensu the following: sprinkler system/sprinkler heads are inspected and maintained monthly, free of debris, the g and valve checks on the fac	gauge	09/12/202

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<u>01</u>	COMP	LETED
		155188	B. WIN	B. WING			/2022
AME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	FIELD HEALTHCAI	RE CENTER			REEN MEADOWS DR NFIELD, IN 46140		
					I		1
X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		5, 2011 edition, Table 5.1.1.2			dry system are recorded wee	-	
	-	red frequency of inspection and			and the sprinkler piping shall		
	-	5.2.4.1 states gauges on wet			be subjected to external load	-	
		ems shall be inspected monthly			materials either resting on th	e pipe	
		systems (5.2.4.2) shall be			or hung from the pipe.		
		o ensure normal water or air			1. What corrective Action wil		
	-	naintained. NFPA 25 13.3.2.1			accomplished for those resid		
		d be inspected weekly or			found to have been affected	by the	
		ks or supervised (13.3.2.1.1)			alleged deficient practice?		
	-	to be inspected monthly. This			No residents were affected I	oy this	
	deficient practice of	could affect all occupants.			alleged deficiency. Sprinkler		
					company contacted to inspec	ct/fix	
	Findings include:				wires and conduit on sprinkle	er	
					piping. Maintenance Director	has	
	During records rev	view and interview with the			cleaned both sprinkler heads	;	
	Maintenance Direc	ctor on 08/24/22 between 10:10			where dust was located.		
	a.m. and 12:45 p.n	n., the Log of gauge and Valve			Maintenance Director and		
	Checks indicated g	gauges on the dry system for			assistant were both educated	d by	
	calendar year 2021	were done each week. For			9/12/2022 on weekly inspect	ion	
	calendar year 2022	they were inspected on 6/17,			and logging the gauge and v	alve	
	2/23 and 1/3 but la	cked other weekly checks. The			checks on the facilities dry		
	Maintenance Direc	ctor stated that he previously			systems.		
	believed the check	s were needed every 6 months			2. How will other residents h	aving	
	but will now begin	checking the gauges and			the same potential to be affe	-	
	valves every week				by the alleged deficient pract	ice	
					be identified and what correct		
	This finding was a	cknowledged by the			action will be taken?		
	-	ctor at the time of discovery and			An audit was completed of a	all	
		onference with the Maintenance			sprinklers/sprinkler piping. N		
		utive Director present at 5:30			other debris, wiring or condu		
	p.m.	-			found on sprinkler heads/pip		
	-				the facility. Maintenance	0	
	2. Based on observ	vation and interview, the facility			Director/Assistant were both		
		1 of 1 sprinkler system in			inserviced by 9/12/2022 on the		
		SC 9.7.5. LSC 9.7.5 requires all			weekly inspections and reco		
		r systems shall be inspected			of the valve and gauge check	-	
	-	accordance with NFPA 25,			the facilities dry system.		
		spection, Testing, and			3. What measures will be put	t into	
		ater-Based Fire Protection			place or systemic changes w		
		5, 2011 edition, 5.2.2.2 requires			made to ensure that the alleg		
	Systems. INFIAZ	5, 2011 cultion, 5.2.2.2 lequiles				yeu	1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X 01	3) DATE SURVEY COMPLETED 08/24/2022
	PROVIDER OR SUPPLIEI		200 GF	ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR NFIELD, IN 46140	
GREENF (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OI sprinkler piping sha loads by materials of hung from the pipe affect 24 residents i Findings include: Based on observati with the Maintenam 12:45 p.m. and 4:42 the entrance contain across and looped a This finding was ac Maintenance Direc again at the exit con Director and Execu p.m. 3. Based on observ failed to ensure spr were not loaded or in accordance with edition, at 5.2.1.1.1 of leakage; shall be materials, paint, an be installed in the c up-right, pendent, o 5.2.1.1.2 any sprink the following shall Corrosion (3) Phys the glass bulb heat Loading (6) Paintir	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION all not be subjected to external either resting on the pipe or . This deficient practice could in one smoke compartment. ons during a tour of the facility ace Director 08/24/22 between 5 p.m., the service-hall attic near ned wire and conduit draped around the sprinkler pipe. Exhowledged by the tor at the time of discovery and nference with the Maintenance tive Director present at 5:30 ation and interview, the facility inkler heads in the laundry area covered with foreign material LSC 9.7.5. NFPA 25, 2011 sprinklers shall not show signs free of corrosion, foreign d physical damage; and shall correct orientation (e.g., or sidewall). Furthermore, at cler that shows signs of any of be replaced: (1) Leakage (2) ical Damage (4) Loss of fluid in responsive element (5) ng unless painted by the urer. This deficient practice			DATE r? o ids on be d t sor PI If I
	Findings include:				
		ons during a tour of the facility ce Director 08/24/22 between			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: **Y3ES21** Facility ID: **000099** 

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FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 155188 B. WING 08/24/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 GREEN MEADOWS DR GREENFIELD HEALTHCARE CENTER **GREENFIELD. IN 46140** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 12:45 p.m. and 4:45 p.m., 2 of 2 sprinkler heads in the clean laundry area were covered in dust or showed signs of loading. The Maintenance Director commented that he believed they were recently cleaned. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b) K 0355 **NFPA 101** SS=E Portable Fire Extinguishers 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 DEEM was working in the facility 09/12/2022 failed to ensure 1 of 30 portable fire extinguishers installing new AC units and their were installed in accordance with NFPA 10, employee pulled this fire Standard for Portable Fire Extinguishers, 2010 extinguisher and had it out back Edition. Section 6.1.3.4 states portable fire as a preventive measure. This fire extinguishers other than wheeled extinguishers extinguisher returned to the 2nd shall be installed using any of the following floor attic area the next day and means. (1) Securely on a hanger intended for the was not used. DEEM had been extinguishers. (2) In the bracket supplied by the doing some welding in the back of extinguisher manufacture. (3) In a listed bracket the facility the day Life Safety approved for such purpose. (3) In a cabinet or wall came in and pulled the recess. This deficient practice was not in a extinguisher from the attic. ED resident care area but could affect staff in the 2nd and Maintenance Director spoke floor attic area. with DEEM about communicating when taking something Findings include: Y3ES21 Event ID: Facility ID: 000099 Page 14 of 31 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 08/24/2022 155188 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 GREEN MEADOWS DR GREENFIELD HEALTHCARE CENTER GREENFIELD, IN 46140 (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., an ABC portable fire extinguisher mount was present in the 2nd floor attic area, near the manual pull station at the exit, but the extinguisher could not be found. The Maintenance Director stated that the extinguisher was usually there, but he was unsure where it went to, HVAC work was being done and he speculated that perhaps when they were sweating in some new connections, the installers grabbed the extinguisher to keep close but did not return it to the holder. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b) K 0363 **NFPA 101** SS=E Corridor - Doors Bldg. 01 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Y3ES21 Event ID: Facility ID: 000099 Page 15 of 31 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

10/04/2022

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STATEMENT OF	F DEFICIENCIES ORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	î î	ILDING	DNSTRUCTION 01	COME	e survey pleted 4/2022
	TIDER OR SUPPLIE			200 GR	ADDRESS, CITY, STATE, ZIP COD EEEN MEADOWS DR IFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETIO DATE
co do if y the ap clo rel pe un mo fra otti un sp all the rel as atti un sp all the rel as atti un sp all the rel as atti the sp atti sp atti sp atti sp atti sp atti the sp atti atti sp atti atti atti atti atti atti atti att	vering is not export complying provided with a e door closed v uplied. There is posing of the doo lease when the ermitted. Nonra- limited height a eeting 19.3.6.3 ames shall be la her materials in aless the smoke rinklered. Fixed owed per 8.3.1 ere are no rest sistance of glas semblies. 0.3.6.3, 42 CFR 3, and 485 now in REMAR e protection rat evices, etc. Based on observa- tied to ensure all apediment to clos ame and would r his deficient prac- sidents. ndings include: ased on observat th the Maintenar (3.5 m, and 4.4 ors failed to late spective door fra	en bottom of door and floor (ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping when a force of 5 lbf is a no impediment to the ors. Hold open devices that door is pushed or pulled are ted protective plates of are permitted. Dutch doors .6 are permitted. Door abeled and made of steel or a compliance with 8.3, e compartment is d fire window assemblies are n sprinklered compartments rictions in area or fire as or frames in window . Parts 403, 418, 460, 482, KS details of doors such as ings, automatics closing ration and interview, the facility corridor doors had no sing and latching into the door esist the passage of smoke. tice could affect 6 staff and 25	K 03	363	K363 It is the policy of the facility ensure all corridor doors h impediment to closing and latching into the door fram resist the passage of smol 1. What corrective Action v accomplished for those res found to have been affecte alleged deficient practice? All doors identified in alleg deficiency were fixed by th maintenance staff. A new knob was installed on corr door in central supply by th	ave no e and ke. will be sidents ed by the ed ne door idor	09/12/202

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		01	COMPL	
		155188	B. WINC		<u>.</u>	08/24/	
				TDEET	ADDRESS, CITY, STATE, ZIP COD		
IAME OF	PROVIDER OR SUPPLIE	ER			REEN MEADOWS DR		
GREEN	FIELD HEALTHCA	RE CENTER			NFIELD, IN 46140		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION	ſF	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		ГAG	DEFICIENCY		DATE
	equipped with a se	-			ambulance entrance.		
		e Closet near resident room #329,			2. How will other residents ha	ving	
	equipped with a se	-			the same potential to be affect	ed	
		e Closet near resident room #330,			by the alleged deficient practic	е	
	equipped with a se	elf-closing device.			be identified and what correction	ve	
					action will be taken?		
		e Closet near resident room #120,			No residents or visitors were		
	equipped with a se	-			affected. Maintenance Directo		
		g Closet near the Ambulance			inspected all remaining corrido	identified.	
		I with a self-closing device.			doors with no issues identified		
			wood Hall, 3. What measures will be put into				
equipped with a self-closing device. place or s	place or systemic changes will						
	g) Shower Do				made to ensure that the allege		
		corridor door in the service hall,			deficient practice does not occ		
	equipped with a se	-			Maintenance and /or Designe	е	
		" corridor door on Brookshire			will make rounds monthly to		
		th a self-closing device. y on Brookshire Hall, equipped			ensure corridor doors have no		
		device, had tape covering the			impediment to closing and		
	latch on the jamb				latching into door frame and resisting the passage of smoke	2	
	laten on the jamos	side.			Maintenance staff educated or		
	This finding was a	cknowledged by the			corridor doors and checking to		
	-	ctor at the time of discovery and			ensure they close properly into		
		onference with the Maintenance			door frame and that the doors	, uic	
	U U	utive Director present at 5:30			resisting the passage of smoke	2	
	p.m.	F F			4. How will the corrective actio		
	1				monitored to ensure the allege		
	2. Based on observation and interview, the facility		deficient practice will not occur				
	failed to ensure 1 of over 30 corridor doors would The Maintenance Supervisor						
	resist the passage	of smoke. This deficient			and/or Designee will ensure th	at	
Fii	practice could affe	ect 6 staff.			all corridor doors shut properly		
					resist the passage of		
	Findings include:				smoke. Maintenance Supervis	sor	
					will report findings to the QA/C	API	
	Based on observat	ions during a tour of the facility			committee monthly X 6 months	s. If	
		nce Director 08/24/22 between			100 % compliance or greater h	nas	
	12:45 p.m. and 4:4	15 p.m., the corridor door at the			not been achieved by the end	of	
		ea near the ambulance entrance			the 6 months, then the monitor	-	
		hich was falling off the door,			will continue until this threshold	b	
	exposing a hole ar	ound the doorknob of			has been reached.		

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Event ID: **Y3ES21** Facility ID: **000099** 

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155188	(X2) MUI A. BUII B. WIN	LDING	DNSTRUCTION 01	COMP	DATE SURVEY COMPLETED 08/24/2022	
	PROVIDER OR SUPPLIE			200 GF	ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR NFIELD, IN 46140			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE	
< 0511 SS=E Bldg. 01	approximately 2 in completely through the passage of smo- commented that it This finding was a Maintenance Direct again at the exit co Director and Exect p.m. 3.1-19(b) NFPA 101 Utilities - Gas and Utilities - Gas and Equipment using complies with NF Code, electrical w complies with NF Code, electrical w complies with NF Code. Existing in service provided 18.5.1.1, 19.5.1.7 Based on observat failed to ensure 3 of provided with grou (GFCI) protection 19.5.1.1 requires u LSC 9.1.2 requires to comply with NF NFPA 70, NEC 20 Circuit-Interrupter states, ground-faul personnel shall be 210.8(A) through ( circuit-interrupter accessible location (B) Other Than Dw single-phase, 15- a	ches which penetrated h the door and would not resist ke. The Maintenance Director was on his list of things to do. cknowledged by the ctor at the time of discovery and inference with the Maintenance attive Director present at 5:30 d Electric gas or related gas piping PA 54, National Fuel Gas wiring and equipment PA 70, National Electric stallations can continue in no hazard to life. 1, 9.1.1, 9.1.2 ion and interview, the facility of over 10 wet locations were against electric shock. LSC tilities comply with Section 9.1. electrical wiring and equipment PA 70, National Electrical Code. 11 Edition at 210.8 Ground-Fault Protection for Personnel, t circuit-interruption for provided as required in (C). The ground-fault shall be installed in a readily	K 05		5. By what date will systemic changes be completed? 9/12/2022 <b>K511</b> 1. What corrective Action w accomplished for those resid found to have been affected alleged deficient practice? The GFCI outlets were insta the following areas: the pant sink near the faucet on the T hall, the freestanding water machine in the Therapy Are Ice Machine on Brookshire I near the nurse's station, and the freestanding water mach Brookshire Hall near the nur station. 2. How will other residents h the same potential to be affee	ill be dents by the alled in try FCU a, the Hall d by hine on rse's aaving	09/12/2022	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155188	B. WING		08/24/2022
JAME OF	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP COD	
				REEN MEADOWS DR	
GREEN	FIELD HEALTHCAI	RECENTER	GREEI	NFIELD, IN 46140	1
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	through (8) shall h	-		by the alleged deficient pract	
		protection for personnel.		be identified and what correct	tive
	(1) Bathrooms			action will be taken?	
	(2) Kitchens			No residents were affected I	
	(3) Rooftops			alleged deficiency. All reside	
	(4) Outdoors			have the potential to be affect	
	· ·	(3) and $(4)$ : Receptacles that are		All outlets were checked and	а
	-	ble and are supplied by a		GFCI was installed where ne	eded.
	branch circuit dedi	cated to electric snow-melting,		3. What measures will be put	t into
	deicing, or pipeline	e and vessel heating equipment		place or systemic changes w	ill be
	shall be permitted	to be installed in accordance		made to ensure that the alleg	ged
	with 426.28 or 427	7.22, as applicable.		deficient practice does not of	ccur?
	Exception No. 2 to	(4): In industrial establishments		Outlets as assigned through	TELS
	only, where the co	nditions of maintenance and		are inspected annually.	
	supervision ensure	that only qualified personnel		Maintenance Staff educated	on
	are involved, an as	sured equipment grounding		proper electrical inspection a	nd
	conductor program	n as specified in 590.6(B)(2)		repair in accordance with NF	
	shall be permitted	for only those receptacle		70, NEC 2011 Edition at 210	
	-	ply equipment that would		Ground-Fault Circuit-Interrup	
	-	zard if power is interrupted or		Protection for Personnel.	
		at is not compatible with GFCI		4. How will the corrective act	ion be
	protection.	1		monitored to ensure the alleg	
	-	receptacles are installed within		deficient practice will not occ	
		outside edge of the sink.		The Maintenance Superviso	
	. ,	(5): In industrial laboratories,		and/or Designee will ensure	
	-	supply equipment where		outlets are inspected	
	<u>^</u>	would introduce a greater		monthly. Maintenance Supe	rvisor
	· ·	mitted to be installed without		and will report findings to the	
	GFCI protection.			QA/QAPI committee monthly	
		(5): For receptacles located in		months. If 100 % compliance	
		ns of general care or critical		greater has not been achieve	
	-	h care facilities other than those		the end of the 6 months, the	
	covered under	i cure fuentites other than those		monitoring will continue until	
		protection shall not be required.		threshold has been reached.	
	(6) Indoor wet loca			5. By what date will systemic	
		with associated showering			
	facilities	with associated showelling		changes be completed?	
		a have and similar areas where		9/12/2022	
		the bays, and similar areas where			
	-	ic equipment, electrical hand			
	tools.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 08/24/2022 155188 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 200 GREEN MEADOWS DR GREENFIELD HEALTHCARE CENTER GREENFIELD, IN 46140 (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 4 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director 08/24/22 between 12:45 p.m. and 4:45 p.m., the following locations lacked GFCI protected outlets or evidence of the presence of a GFCI circuit; 1. The Pantry sink near the faucet on the TCU Hall. 2. The freestanding water machine in the Therapy Area. 3. The Ice Machine on Brookshire Hall near the nurse's station. 4. The freestanding water machine on Brookshire Hall near the nurse's station. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m. 3.1-19(b) K 0712 **NFPA 101** SS=C Fire Drills Bldg. 01 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected Facility ID: 000099 Y3ES21 Page 20 of 31 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE C A. BUILDING B. WING	<u>01</u>	x3) date survey completed 08/24/2022
	PROVIDER OR SUPPLIE		200 GF	ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR NFIELD, IN 46140	
(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 APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
	<ul> <li>conditions, at lease The staff is familiar aware that drills are routine. Where d 9:00 PM and 6:00 announcement maudible alarms.</li> <li>19.7.1.4 through</li> <li>1. Based on record facility failed to counce pected days are varying conditions affect all residents,</li> <li>Findings include:</li> <li>During records rev Maintenance Direct a.m. and 12:45 p.m.</li> <li>conducted near the 28th and 31st day of do not allow fire dhan unexpected times.</li> <li>fire drills were the quarter, 11 a.m. for third shift and 5 p.m.</li> <li>This finding was and Maintenance Direct again at the exit co Director and Execut p.m.</li> <li>2. Based on record facility failed to coo orientation training 2021. LSC 19.7.1.0 quarterly on each st</li> </ul>	ay be used instead of	K 0712	K712 It is the policy of the facility to conduct quarterly fire drills o unexpected days and at unexpected times under varying conditions. 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The maintenance director wil conduct fire drills quarterly o each shift. The Administrator/designee will audit all new employee files for documented orientation training. 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? This deficient practice could affect all residents, staff and	n I II n

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	· · · · · · · · · · · · · · · · · · ·				
GREEN	PROVIDER OR SUPPLIE	RE CENTER		200 GF	ADDRESS, CITY, STATE, ZIP REEN MEADOWS DR NFIELD, IN 46140 1	COD	(15)
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
TAG	engineers, and adm signals and emerge varied conditions. waiver states in lie documented orient to the current fire p facility conditions instruct employees temporary employ safety procedures in their assigned at affects all staff and Findings include: During records rev Maintenance Direc a.m. and 12:45 p.m quarter were missi completed fire dril training. The Maintenance I his time began at t what happened. This finding was a Maintenance Direc again at the exit co	R LSC IDENTIFYING INFORMATION inistrative staff) with the ency action required under QSO-20-31 1135 temporary u of a physical fire drill, a ation training program related blan, which considers current is acceptable. The training will a including existing, new or ees, on their current duties, life and the fire protection devices rea. This deficient practice I patients. Fiew and interview with the etor on 08/24/22 between 10:10 h., all shifts during the fourth ng documented orientation Director stated that was before the facility and he was unsure ecknowledged by the etor at the time of discovery and onference with the Maintenance attive Director present at 5:30		TAG	<ul> <li>Visitors in the facility Maintenance staff with routine fire drills at ut times on each shift.</li> <li>3. What measures with into place or system will be made to ensure alleged deficient pra- not occur?</li> <li>Administrator and Maintenance staff with educated on conduct drills/completion on on unexpected days Administrator will au drill records monthly months.</li> <li>4. How will the corre- action be monitored the alleged deficient will not occur?</li> <li>The Maintenance S and/or Designee will fire drills are comple- monthly on each shi policy at different tim recorded appropriate TELS system. Mainte Supervisor will repor- to the QA/QAPI com- monthly X 6 months, compliance or greate been achieved by the the 6 months, then the monitoring will conting</li> </ul>	y. ill perform unexpected vill be put ic changes ire that the ictice does as ting fire fire drills and times. udit fire y for 6 ective to ensure practice upervisor ensure eted ift per nes and ely via tenance rt findings mittee . If 100 % er has not e end of he	DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	ì í	JILDING	ONSTRUCTION 01	COMI	e survey pleted <b>4/2022</b>
	PROVIDER OR SUPPLIE			200 GF	ADDRESS, CITY, STATE, ZIP CO REEN MEADOWS DR NFIELD, IN 46140	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)		RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
					reached. 5. By what date will s changes be completed 9/12/2022	-	
K 0761 SS=F Bldg. 01	interview, the facil inspection and test assemblies were co 19.1.1.4.1.1 comm fire barriers require permitted only in c by approved self-c (See also Section & required to have a 8.3.4.2 shall be pro- labeled fire door as assemblies and the including all frame and sills in accorda NFPA 80, Standard Opening Protective specified in this Co door assemblies shall be by the AHJ. NFPA assemblies shall be sides to assess the assembly. NFPA 8 the following items	or breaks exist in surfaces of	y failed to ensure annual1. 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 remaining 10 o 12 fire doors.y 19.1.1.4.1 shall be ridors and shall be protected sing fire door assemblies. .) LSC 8.3.3.1 Openings e protection rating by Table cted by approved, listed, emblies and fire window accompanying hardware, closing devices, anchorage, ce with the requirements of for Fire Doors and Other e. NFPA 80 5.2.1 states fire l be inspected and tested not ad a written record of the gned and kept for inspection 0, 5.2.4.1 states fire door isually inspected from both reall condition of door1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Doors and Other 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 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		e residents ected by the ce? was nining 10 of ents having e affected t practice corrective s were e door ted on the d be put into ges will be e alleged not occur? spected ted in ector and	09/12/2023	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>01</u>	COMF	e survey pleted 4/2022
	PROVIDER OR SUPPLIE		200 GI	ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR NFIELD, IN 46140		
				1		(775)
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETIC DATE
	<ul> <li>(2) Glazing, vision are intact and secu equipped.</li> <li>(3) The door, fram noncombustible th and in working ord damage.</li> <li>(4) No parts are m</li> <li>(5) Door clearance listed in 4.8.4 and</li> <li>(6) The self-closin the active door con from the full open</li> <li>(7) If a coordinato closes before the a</li> <li>(8) Latching hardw door when it is in</li> <li>(9) Auxiliary hard prohibit operation frame.</li> <li>(10) No field mod have been perform</li> <li>(11) Gasketing and inspected to verify This deficient prace</li> <li>Findings include:</li> <li>During records rev Maintenance Direct a.m. and 12:45 p.r. annual inspection assemblies was av Inspection Documa assemblies (Brook Activities Area) w doors assemblies of documentation. Th he had not done an</li> </ul>	n light frames, and glazing beads arely fastened in place, if so ne, hinges, hardware, and areshold are secured, aligned, der with no visible signs of issing or broken. es do not exceed clearances 6.3.1.7. Ig device is operational; that is, mpletely closes when operated position. r is installed, the inactive leaf		via the TELS system. 4. How will the corrective au monitored to ensure the alle deficient practice will not or The Maintenance Supervis and/or Designee will ensure doors are inspected and iss documented accordingly monthly. Maintenance Sup will report findings to the Q/ committee monthly X 6 mon 100 % compliance or greate not been achieved by the e the 6 months, then the mon will continue until this thresh has been reached. 5. By what date will system changes be completed? 9/12/2022	eged ccur? e that sues ervisor A/QAPI hths. If er has nd of htoring hold	DATE

PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION         PREFIX TAG         CACATORNAL DESCIDENTIFYING INFORMATION         COMPLE TAG           This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m.         This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m.         Sile of the present at 5:30 p.m.		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE C A. BUILDING B. WING	construction <u>01</u>	(X3) DATE S COMPLE 08/24/2	ETED
PREFIX TAO         (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION         PREFIX TAG         CARAGEMENT AS ARE STREETED CONSERTERENCED TO THE APPROPRIATE DATE         COMPLE           This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m.         This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m.         See Find See Find Electrical Systems - Maintenance and Testing         See Find Electrical Systems - Maintenan				200 G	REEN MEADOWS DR		
Maintenace Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present at 5:30 p.m.3.1-19(b)X 0914SS=F Bldg.01Electrical Systems - Maintenance and TestingElectrical System - Maintenance and TestingElectrical System - Maintenance and TestingElectrical System - Maintenance and testing is performed at intervals activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 mon	PREFIX	(EACH DEFICIE)	Y STATEMENT OF DEFICIENCIE ID PROV ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO CROSS-REF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF	BE	(X5) COMPLETIO DATE
6.3.4 (NFPA 99)	< 0914 SS=F	This finding was a Maintenance Direct again at the exit co Director and Exect p.m. 3.1-19(b) NFPA 101 Electrical System Testing Electrical System Testing Hospital-grade re locations and wh anesthesia is adr initial installation, Additional testing defined by docun Receptacles not these locations a exceeding 12 mo (LIM), if installed, less than or equa the LIM test switc activates both vis LIM circuits with a manual test is pe than or equal to 7 tested per 6.3.3.3 renovation to the Records are main associated repair containing date, n results. 6.3.4 (NFPA 99) Based on record re	ecknowledged by the extor at the time of discovery and onference with the Maintenance attive Director present at 5:30 as - Maintenance and as - Maintenance and eceptacles at patient bed ere deep sedation or general ministered, are tested after replacement or servicing. It is performed at intervals nented performance data. Listed as hospital-grade at re tested at intervals not onths. Line isolation monitors are tested at intervals of al to 1 month by actuating ch per 6.3.2.6.3.6, which sual and audible alarm. For automated self-testing, this rformed at intervals less 12 months. LIM circuits are 8.2 after any repair or electric distribution system. ntained of required tests and rs or modifications, room or area tested, and		-		09/12/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPL A. BUILDIN B. WING	le construction G <u>01</u>	COME	E SURVEY PLETED
				EET ADDRESS, CITY, STATE, ZIP	_	4/2022
	PROVIDER OR SUPPLIE			GREEN MEADOWS DR EENFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
	Health Care Facili 6.3.4.1.3 states rec hospital-grade at p locations where de anesthesia shall be exceeding 12 mon Facilities Code, 20 states hospital-grad performed after in servicing of the de Receptacle Testing the physical integr confirmed by visua the grounding circ shall be verified. On neutral connection shall be confirmed grounding blade of (except locking-ty) than 115 grams (4)	the with NFPA 99. NFPA 99, the Code, 2012 Edition, Section eptacles not listed as atient bed locations and in ep sedation or general tested at intervals not ths. NFPA 99, Health Care 12 Edition, Section 6.3.4.1.1 de receptacles testing shall be tial installation, replacement or vice. Section 6.3.3.2, g in Patient Care Rooms requires ity of each receptacle shall be al inspection. The continuity of uit in each electrical receptacle Correct polarity of the hot and s in each electrical receptacle g; and retention force of the f each electrical receptacle pe receptacles) shall be not less ounces). Section 6.3.4.2.1.2 m, the record shall contain the		outlet receptacle test completed annually a resident rooms. 1. What corrective A be accomplished for residents found to ha affected by the allege deficient practice? The maintenance difference of the receptacles in reside are tested within a 12 period. 2. How will other re having the same pot be affected by the all deficient practice be and what corrective of be taken?	at all Action will those ave been ed rector will outlet ent rooms 2 month sidents ential to leged identified	
	date, the rooms or of which items have the performance re This could affect a Findings include: During records rev Maintenance Direct a.m. and 12:45 p.m inspection and test within the most ret not available for re documentation wa electrical receptact and the beginning	areas tested, and an indication we met, or have failed to meet, quirements of this chapter.		All residents have the potential to be affect Maintenance staff to receptacle testing in resident rooms. 3. What measures we into place or system will be made to ensue alleged deficient pray not occur? The Executive Direct audit 6 tests results 12 months. Maintenane educated on complete the state of the	ed. complete all vill be put ic changes ire that the ctice does etor will a month for ance staff	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	COM	e survey pleted <b>4/2022</b>
	PROVIDER OR SUPPLIE		200 GF	ADDRESS, CITY, STATE, ZIP CO REEN MEADOWS DR NFIELD, IN 46140	D	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C Director during a t sleeping room had installed near resid This finding was a Maintenance Direc again at the exit co	X STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION cour of the facility each resident multiple electrical receptacles	ID PREFIX TAG	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) receptacle testing in re rooms annually. Task r via TELS to ensure rec testing is completed. 4. How will the correct action be monitored to the alleged deficient pr will not occur? The Maintenance Sup and/or Designee will er outlets in residents roo tested annually. Mainter staff will complete test rooms a week until compliance is met. Maintenance Sup will report findings to t	volub BE PROPRIATE esidents reminder eptacle tive ensure ractice ervisor nsure all oms are enance ing in 10	(X5) COMPLETION DATE
< 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extens	nent - Power Cords and		QA/QAPI committee me 6 months. If 100 % com or greater has not beer achieved by the end of months, then the monit will continue until this threshold has been rea 5. By what date will systemic changes be completed? 9/12/2022	npliance n the 6 toring	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155188	r í	VILDING	onstruction <u>01</u>	COMP	DATE SURVEY COMPLETED 08/24/2022	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR			
GREEN	FIELD HEALTHCA	RECENTER		GREE	NFIELD, IN 46140			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y 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 APPROPRI/ DEFICIENCY)	ΛTE	(X5) COMPLETIO DATE	
	Power strips in a used for compon patient-care-relat (PCREE) assem assembled by qu the conditions of the patient care w non-PCREE (e.g except in long-tel do not use PCRE meet UL 1363A of for non-PCREE i (outside of vicinit non-patient care other UL standar used with genera cords are not use wiring of a structu temporarily are ro completion of the installed and mea 10.2.3.6 (NFPA S (NFPA 70), 590.3 Based on observat failed to ensure 2 of were not used as a wiring. NFPA-70/ specifically permit cables shall not be fixed wiring. Artic chains, because the strip) is now acting wiring of a structu affect up to 6 staff Findings include: Based on observat with the Maintena	patient care vicinity are only ents of movable red electrical equipment bles that have been alified personnel and meet 10.2.3.6. Power strips in vicinity may not be used for ., personal electronics), rm care resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms y) meet UL 1363. In rooms, power strips meet ds. All power strips are al precautions. Extension ed as a substitute for fixed ure. Extension cords used emoved immediately upon a purpose for which it was ets the conditions of 10.2.4. 29), 10.2.4 (NFPA 99), 400-8 3(D) (NFPA 70), TIA 12-5 ion and interview, the facility of 2 power cord daisy chains and as a substitute for fixed 2011, 400.8 state unless ted in 400.7 flexible cords and used for (1) as a substitute for de 400.8 (1) prohibits daisy e first extension cord (or power g as a substitute for the fixed re. This deficient practice could	K 09		<b>K920</b> 1. What corrective Action will accomplished for those reside found to have been affected b alleged deficient practice? The maintenance director immediately unplugged and removed the power strip that plugged in to the other power from the physicians lounge. 2. How will other residents ha the same potential to be affect by the alleged deficient practic be identified and what correct action will be taken? No residents/staff or visitors of affected. The power strip was	ents by the was strip aving ted ce ive were	09/12/202	

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	es X1) provider/supplier/clia identification number 155188	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 08/24/2022	
NAME OF PROVIDER OR SUI		200 GI	ADDRESS, CITY, STATE, ZIP CO REEN MEADOWS DR NFIELD, IN 46140	DC		
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIE ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETIO DATE	
a power strip         strip. Based or         observation, th         power strips w         This finding w         Maintenance I         again at the ex         Director and F         p.m.         3.1-19(b)         X0927         NFPA 101         SS=E         Gas Equipmed	ent - Transfilling Cylinders		<ul> <li>immediately removed in physicians lounge by the Maintenance Director.</li> <li>3. What measures will be place or systemic change made to ensure that the deficient practice does of the maintenance direct perform monthly audits this deficient practice does on the monthly audits this deficient practice does on the facilities numpractitioners and mainter staff was educated on the power strips and not plue power strips and not plue power strip into another strip.</li> <li>4. How will the corrective monitored to ensure the deficient practice will not the Maintenance Super and/or Designee will perform monthly rounds to ensure the deficient practice will not the strips and issues docum accordingly. Maintenar Supervisor will report find the QA/QAPI committee X 6 months. If 100 % cord greater has not been by the end of the 6 mort the monitoring will contribution this threshold has been 5. By what date will systemages be completed 29/12/2022</li> </ul>	e put into ges will be e alleged not occur? ctor will to ensure oes not se enance he use of ugging a r power ve action be e alleged ot occur? ervisor erform ire power nented noce ndings to e monthly compliance a achieved oths, then inue until reached. stemic		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER 155188	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING			(X3) DATE SURVEY COMPLETED 08/24/2022	
NAME OF PROVIDER OR SUPPLIERSTREET ADDRESS, CITY, STATE, ZIP CODGREENFIELD HEALTHCARE CENTER200 GREEN MEADOWS DRGREENFIELD, IN 46140GREENFIELD, IN 46140							
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		E	(X5) COMPLETIO DATE
	Transfilling of Hi Oxygen Used fo any gas from on prohibited in patt to liquid oxygen containers over under 11.5.2.3.1 liquid oxygen co containers unde conditions under 11.5.2.2 (NFPA Based on observa failed to ensure 1 where oxygen transprovided with pro- ventilation. NFP requires compare findings include: Based on observa with the Maintena 12:45 p.m. and 4: storage/transfer re- large liquid oxyge mechanically ven appear to be work detected, and whe opening, no evide observed. The Ma the fan did not ap	tion and interview, the facility of 2 oxygen storage rooms insferring takes place, was operly working mechanical A 99 2012 edition, 11.5.2.3.1 (2) ransfilling rooms to be tilated. Section 9.3.7.5.3.1 cal exhaust to maintain a in the space continuously. This could affect up to 15 residents in artment. tions during a tour of the facility ance Director 08/24/22 between 45 p.m., the oxygen oom on Rosebud Hall contained en tanks. The room did have a tilated exhaust fan, but it did not ting. No fan noise could be in paper was held near the vent ince of suction could be uintenance Director stated that pear to be working or at least r out of the room sufficient	KO	927	<ul> <li>K927</li> <li>It is the policy of the facility to ensure there is properly working mechanical ventilation where oxygen transferring takes place.</li> <li>1. What corrective Action will be accomplished for those residen found to have been affected by alleged deficient practice.</li> <li>The maintenance director installed a new exhaust fan in the oxygen transfilling room of Rosewood.</li> <li>How will other residents havit the same potential to be affected by the alleged deficient practice be identified and what correctivation will be taken?</li> <li>No residents were affected by this alleged deficiency.</li> <li>Maintenance director installed a new working exhaust fan in the oxygen transfilling room of Rosewood.</li> <li>What measures will be put in place or systemic changes will made to ensure that the alleged will</li> </ul>	e tts the on ng ed e y d on tto be	09/12/202

STATEME	ARTMENT OF HEALTH AND HUMAN SERVICES TERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155188		(X2) MULTIPLE CC A. BUILDING B. WING	FORM APPROVEI OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 08/24/2022		
	PROVIDER OR SUPPLIE		200 GF	ADDRESS, CITY, STATE, ZIP COD REEN MEADOWS DR NFIELD, IN 46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O This finding was au Maintenance Direc again at the exit co	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> cknowledged by the tor at the time of discovery and inference with the Maintenance itive Director present at 5:30	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) deficient practice does not occ All other oxygen rooms in the facility were checked with ne findings. The maintenance director/designee will perfor monthly rounds as part of the preventive maintenance program to ensure the oxyget transfilling rooms have work mechanical ventilation. Maintenance staff was educated on ventilation in the oxygen transfilling rooms. 4. How will the corrective action monitored to ensure the allege deficient practice will not occu. The Maintenance Supervisor and/or Designee will ensure the all oxygen transfilling rooms he proper working mechanical ventilation. Maintenance Supervisor will report findings the QA/QAPI committee mont X 6 months. If 100 % complia or greater has not been achie by the end of the 6 months, the the monitoring will continue un this threshold has been reach 5. By what date will systemic changes be completed?	cur? he o m ne en king he king ha hat hat have thly ance eved hance eved hance hanc hanc hanc hanc hanc hanc	(X5) COMPLETION DATE

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