STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING -- B. WING	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD 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: 05/30/24 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Emergency Preparedness survey, Greenwood Health & Living Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 121 certified beds. At the time of the survey, the census was 98. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review conducted on 06/03/24	E 0000	This letter is to inform you that the plan of correction attached is to serve as Greenwood Health and Livings credible allegation of compliance. We allege substantial compliance on June 18, 2024. We are requesting paper compliance for this plan of correction. Submission of this plan of correction in no way constitutes an admission by Greenwood Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorian Mihay	Administrator	06/21/2024

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	§441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must			

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	develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to maintain 1 of 2 emergency preparedness plans that were reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the Administrator's version of "Emergency Disaster Manual" documentation dated 01/28/20 with the Corporate Director of Facilities during record review from 12:00 p.m. to 1:10 p.m. on 05/30/24, documentation for the Administrator's version of emergency preparedness program was not reviewed within the most recent twelve month period. The aforementioned plan was dated as being reviewed on 01/28/20 which was not within the most recent twelve month period. Based on interview at the time of record review, the Corporate Director of Facilities stated the Administrator maintains a smaller version of the more complete version of "Emergency Disaster Preparedness Manual" documentation which was dated 01/12/24 which was within the most recent twelve month period. Based on interview at the time of record review, the Corporate Director of Facilities agreed the Administrator's version of emergency preparedness program documentation was not documented as being reviewed within the most recent twelve month period. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.	E 0004	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the Administrators copy of the Emergency Disaster Manual has been reviewed and updated in the last 12 months. The Administrator, DON, and Maintenance Supervisor have updated all copies of the Emergency Disaster Manual. See attached E004 I. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the community have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There has been a new annual	06/18/2024

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			TELS task added for January of every year to ensure the Emergency Manual is reviewed and updated. See attached TELS task labeled “E004 III. Greenwood Emergency Manual TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will review this information during their annual Corporate Quality Review to ensure that the Emergency Disaster Manuals are up to date. **V. Plan of Correction completion date.** Plan of Completion date is June 18th, 2024.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2),			

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	§485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must			

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	do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include	E 0006	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure the risk assessment in the Emergency Disaster Preparedness Manual had Infectious Disease as a risk for Greenwood Health and Living. Furthermore, Infectious Disease was not included in the policy and procedures at the community. The Administrator, DON, and Maintenance Supervisor have updated the all hazards risk	06/18/2024

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	Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of the "Emergency Disaster Preparedness Manual" documentation dated 01/12/24 with the Corporate Director of Facilities during record review from 12:00 p.m. to 1:10 p.m. on 05/30/24, the documented facility-based and community-based risk assessment for emerging infectious disease (EID) threats was scored as zero percent. EID was not included in the current policies and procedures section of emergency preparedness program documentation for the facility. Based on interview at the time of record review, the Corporate Director of Facilities agreed emergency preparedness program documentation did not address emerging infectious diseases (EID) as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.		assessment and reviewed the policy and procedure for such an event. See attached E006 I. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the community have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There has been a new annual TELS task added for January of every year to ensure the Emergency Manual is reviewed and updated. See attached TELS task labeled " E006 III. Greenwood Emergency Manual TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will review this information during their annual Corporate Quality Review to ensure that the annual risk assessment includes Infectious Disease.	

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			V. Plan of Correction completion date. Plan of Completion date is June 18th, 2024.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.			

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	*Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update its emergency	E 0013	**I. The corrective actions to be accomplished for those**	06/18/2024

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	preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID). The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of the "Emergency Disaster Preparedness Manual" documentation dated 01/12/24 with the Corporate Director of Facilities during record review from 12:00 p.m. to 1:10 p.m. on 05/30/24, emergency preparedness policies and procedures addressing EID was not available for review. Based on interview at the time of record review, the Corporate Director of Facilities agreed emergency preparedness policies and procedures addressing EID was not available for review. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.		**residents found to have been affected by the deficient practice.** Observation - The community failed to ensure the risk assessment in the Emergency Disaster Preparedness Manual had Infectious Disease as a risk for Greenwood Health and Living. Furthermore, Infectious Disease was not included in the policy and procedures at the community. The Administrator, DON, and Maintenance Supervisor have updated the all hazards risk assessment and reviewed the policy and procedure for such an event. See attached E013 I. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the community have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There has been a new annual TELS task added for January of every year to ensure the Emergency Manual is reviewed	

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			and updated. See attached TELS task labeled " E013 III. Greenwood Emergency Manual TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will also review this information during their annual Corporate Quality Review to ensure that the annual risk assessment includes Infectious Disease. **V. Plan of Correction completion date.** Plan of Completion date is June 18th, 2024.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.			

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	§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS			

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	Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition,			

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	155412	A. BUILDING -- B. WING	05/30/2024

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	including TIAs to chapter 7, issued August 6, 2009..			
	Based on observation and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor during the initial walk through of the facility at 8:55 a.m. on 05/30/24, the "GEN POWER" indicator light was illuminated in yellow on the facility's wall mounted emergency generator annunciator panel located at the north nurse's station. Based on interview at the time of the observations, the Maintenance Supervisor stated the emergency generator is not currently running, the generator was running last week and the light should have gone off once power was transferred back to the normal source last week. The Maintenance Supervisor stated building power could be transferred to the generator if there was a loss of power and stated he would contact the generator contractor for repair today. Based on observations with the Administrator, the Maintenance Supervisor and the Corporate Director of Facilities during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 05/30/24, the "GEN POWER" light was still illuminated in yellow. Based on interview at the time of the observations, the Maintenance Supervisor stated the contractor was currently on site for repairs but the annunciator panel needed to be reprogrammed which required a different contractor to come on site at a later time who was more familiar with reprogramming the panel.	E 0041	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the Emergency Generator interior annunciator was showing the correct lights. The run light was illuminated indicating that the generator was running and it was not. Part has been ordered and part has been scheduled to be repaired. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the community have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated to inspect the interior generator annunciator panel during his weekly run tests to ensure the proper lights are	06/18/2024

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	These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.		illuminated. See attached E041 III. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will also review the generator annunciator during their annual Corporate Quality Review to ensure that the appropriate lights are illuminated. **V. Plan of Correction completion date.** Plan of Completion date is June 18th, 2024.	
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: 05/30/24 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Life Safety Code survey, Greenwood Health And Living Community was found not in compliance with Requirements for Participation in	K 0000	This letter is to inform you that the plan of correction attached is to serve as Greenwood Health and Livings credible allegation of compliance. We allege substantial compliance on June 18, 2024. We are requesting paper compliance for this plan of correction. Submission of this plan of correction in no way constitutes an admission by Greenwood Health and Living or its management company that the	

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	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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 121 and had a census of 98 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review conducted on 06/03/24		allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 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.			

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	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 60 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 517. Findings include: Based on observations with the Administrator, the Maintenance Supervisor and the Corporate Director of Facilities during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 05/30/24, the	K 0363	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The Community failed to ensure that resident room 517 corridor door latched properly into the door frame. The Maintenance Supervisor has reworked the door so it will latch properly into the door frame. See attached photos K363 I.	06/18/2024

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	latching mechanism on the corridor door to resident sleeping Room 517 failed to protrude into the latching plate on the door frame which prevented the corridor door from fully closing and latching into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Supervisor agreed the corridor door to resident sleeping Room 517 had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents in resident room 517 have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- There is a TELS task to inspect corridor doors every 3 months to ensure that they close and latch properly. See attached TELS task labeled " K363 III. Greenwood Corridor Door TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect these areas during their annual Corporate Quality Review to ensure resident room doors in the community shut and latch properly. **V. Plan of Correction completion date.** Plan of Completion date is June	

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			18th, 2024.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 8 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by Room 504. Findings include: Based on observations with the Administrator, the Maintenance Supervisor and the Corporate Director of Facilities during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 05/30/24, three	K 0372	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The Community failed to ensure that the fire smoke barrier wall near resident room 504 maintained a consistent fire rating. 3 separate holes were found in the smoke barrier wall. The Maintenance Supervisor has patched these penetrations. See attached pictures showing these areas sealed and corrected K372 I.	06/18/2024

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	separate holes were noted in the attic smoke barrier wall above the corridor door set by Room 504. The attic smoke barrier wall consisted of one layer of 5/8th's inch thick drywall on each side of the wall stud. The holes were the annular space surrounding a four inch in diameter horizontal sprinkler pipe which penetrated the wall, a three inch by one inch rectangular shaped hole in the wall by the sprinkler pipe for the passage of data cables through the wall and a three inch in diameter open ended gray conduit also for the passage of data cables through the wall. Each door in the corridor door set by Room 504 was equipped with a 20 minute fire resistance rating label on the door and each door latched into the door frame when tested to close. Based on interview at the time of the observations, the Maintenance Supervisor agreed the aforementioned openings in the smoke barrier wall above the corridor door set by Room 504 were not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents near 500 hall have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- There is a TELS task to inspect all smoke barriers every 6 months to ensure that there are no open penetrations. See attached TELS task labeled " K372 III. Greenwood Smoke Barrier Inspection TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect these areas during their annual Corporate Quality Review to ensure there are no open penetrations. **V. Plan of Correction**	

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			completion date. Plan of Completion date is June 18th, 2024.	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview, the facility failed to ensure smoking materials were deposited	K 0741	**I. The corrective actions to be accomplished for those**	06/18/2024

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	into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor area where smoking was taking place. This deficient practice could affect over 2 staff. Findings include: Based on observations with the Administrator, the Maintenance Supervisor and the Corporate Director of Facilities during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 05/30/24, over 10 cigarette butts were extinguished in sand enclosed in a open top ash tray on top of an open sided trash can located outside the facility near the service hall exit by the kitchen. A metal container with self-closing cover devices was not provided at this outdoor location where smoking was taking place. Based on interview at the time of the observations, the Maintenance Supervisor stated the area was a staff smoking area and agreed a metal container with self-closing cover devices was not provided at this outdoor location where smoking was taking place. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice.** Observation 1– The community failed to ensure that the smoke free campus policy was being enforced and there was a proper cigarette disposal can onsite. The trash can with ash tray was removed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and associates have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Administrator has re educated the associates that our smoking policy is that all associates must smoke in their vehicles. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect these areas during their annual Corporate Quality Review	

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			to ensure that the facility remains a smoke free campus. **V. Plan of Correction completion date.** Plan of Completion date is June 18th, 2024.	
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels were in proper operating condition. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Supervisor during the initial walk through of the facility at 8:55 a.m. on 05/30/24, the "GEN POWER" indicator light was illuminated in yellow on the facility's wall mounted emergency generator annunciator panel located at the north	K 0916	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the Emergency Generator interior annunciator was showing the correct lights. The run light was illuminated indicating that the generator was running and it was not. Part has been ordered and	06/18/2024

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	nurse's station. Based on interview at the time of the observations, the Maintenance Supervisor stated the emergency generator is not currently running, the generator was running last week and the light should have gone off once power was transferred back to the normal source last week. The Maintenance Supervisor stated building power could be transferred to the generator if there was a loss of power and stated he would contact the generator contractor for repair today. Based on observations with the Administrator, the Maintenance Supervisor and the Corporate Director of Facilities during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 05/30/24, the "GEN POWER" light was still illuminated in yellow. Based on interview at the time of the observations, the Maintenance Supervisor stated the contractor was currently on site for repairs but the annunciator panel needed to be reprogrammed which required a different contractor to come on site at a later time who was more familiar with reprogramming the panel. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		part has been scheduled to be repaired. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the community have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated to inspect the interior generator annunciator panel during his weekly run tests to ensure the proper lights are illuminated. See attached K916 III. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will also review the generator annunciator during their annual Corporate Quality Review to ensure that the appropriate lights are illuminated. **V. Plan of Correction**	

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K 0920 SS=E 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 (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 cord, including a power strip, was 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	K 0920	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	06/18/2024

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(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
	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. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Marketing Director's office near the main entrance lobby. Findings include: Based on observations with the Administrator, the Maintenance Supervisor and the Corporate Director of Facilities during a tour of the facility from 1:35 p.m. to 3:15 p.m. on 05/30/24, a refrigerator, a microwave oven and a coffee maker were plugged into a wall mounted power strip in the Marketing Director's office near the main entrance lobby. Based on interview at the time of the observations, the Administrator, the Maintenance Supervisor and the Corporate Director of Facilities agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		Observation - The community failed to ensure that all appliances within the community were plugged into appropriate outlets. There was a power strip in the admissions office with a coffee pot, microwave, and refrigerator plugged into it. The Maintenance Supervisor has added a double outlet for the small appliances. See attached K920 I. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Staff and residents in the marketing office area have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated on the use of power strips and small appliances. An every 3 month TELS task was created to inspect the entire community to ensure that all small appliances are plugged directly into an outlet and that all power strips and in use correctly. See attached TELS Task labeled " K920 III. Greenwood Power Strip Audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 01 B. WING	05/30/2024

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			TELS Task." **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will also inspect the entire community during their annual Corporate Quality Review to ensure that Appliances and power strips are in use correctly. **V. Plan of Correction completion date.** Plan of Completion date is June 18th, 2024.	