STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/30/2024	
	PROVIDER OR SUPPLIE VOOD HEALTH AN	R ND LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142			
(X4) ID PREFIX TAG E 0000	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg	conducted by the I accordance with 42 Survey Date: 05/3 Facility Number: Provider Number: AIM Number: 100 At this Emergency Greenwood Health found not in comp. Preparedness Required Medicaid Participa CFR 483.73. The facility has 12 the survey, the center at MET as evidenced Quality Review compared to the survey of the sur	0/24 000509 155412 0266620 Preparedness survey, & Living Community was liance with Emergency direments for Medicare and ting Providers and Suppliers, 42 1 certified beds. At the time of sus was 98.  142 CFR, Subpart 483.73 is NOT by: Inducted on 06/03/24	E 00	000	This letter is to inform you that plan of correction attached is a serve as Greenwood Health a Livings credible allegation of compliance. We allege substantial compliance on Jur 18, 2024. We are requesting paper compliance for this plan correction.  Submission of this plan of correction in no way constitute an admission by Greenwood Health and Living or its management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nucare or other services provide this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.  This statement of deficiencies plan of correction will be revie at the Monthly Quality Assurance/Assessment Committee meeting.	to nd ne of es e urvey ursing d in	
E 0004 SS=F Bldg	484.102(a), 485.6 485.727(a), 485.6 491.12(a), 494.62 Develop EP Plan Annually	15(a), 483.475(a), 483.73(a), 625(a), 485.68(a), 920(a), 486.360(a),					

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

(X6) DATE

TITLE

Dorian Mihay Administrator 06/21/2024

Any defiency statement 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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	ľ	UILDING	NSTRUCTION	(X3) DATE COMPL 05/30/	ETED	
	PROVIDER OR SUPPLIER	RID LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	§483.73(a), §483. §485.68(a), §485. §485.920(a), §486. §494.62(a).	0.84(a), §482.15(a), 475(a), §484.102(a), 625(a), §485.727(a), 6.360(a), §491.12(a),						
	Federal, State and preparedness requist develop esta comprehensive eleprogram that mee section. The emel	comply with all applicable d local emergency uirements. The [facility] ablish and maintain a mergency preparedness the requirements of this regency preparedness lude, but not be limited to, nents:						
	develop and main preparedness pla	an. The [facility] must tain an emergency n that must be [reviewed], ast every 2 years. The plan following:						
	§485.625(a):] Emor CAH] must con Federal, State, an preparedness req CAH] must develor comprehensive en program that mee	§482.15 and CAHs at ergency Plan. The [hospital hply with all applicable and local emergency uirements. The [hospital or op and maintain a mergency preparedness to the requirements of this in all-hazards approach.						
	develop and main	The LTC facility must tain an emergency n that must be reviewed,						
		ities at §494.62(a):] The ESRD facility must						

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Event ID:

Z3DZ21

Facility ID: 000509

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/30/2024	
	PROVIDER OR SUPPLIER	ID LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	FIX  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
		tain an emergency n that must be [evaluated], ast every 2 years.					
	failed to maintain 1 plans that were reviannually in accorda	of 2 emergency preparedness ewed and updated at least nee with 42 CFR 483.73(a). ice could affect all occupants.	E 0	004	I. The corrective actions to I accomplished for those residents found to have been affected by the deficient practice.  Observation - The community	n	06/18/2024
	"Emergency Disast dated 01/28/20 with Facilities during red 1:10 p.m. on 05/30/ Administrator's ver preparedness progra the most recent twe aforementioned pla on 01/28/20 which	am was not reviewed within lve month period. The n was dated as being reviewed was not within the most recent	failed to ensure that the Administrators copy of Emergency Disaster M been reviewed and upol last 12 months. The Ad DON, and Maintenance have updated all copies Emergency Disaster M attached E004 I.  II. The facility will ide other residents that m		Administrators copy of the Emergency Disaster Manual I been reviewed and updated ir last 12 months. The Administr DON, and Maintenance Supe have updated all copies of the Emergency Disaster Manual. attached E004 I.	n the rator, rvisor	
	time of record revie Facilities stated the smaller version of t	d. Based on interview at the ew, the Corporate Director of Administrator maintains a he more complete version of er Preparedness Manual"			other residents that may potentially be affected by the	Đ	
	documentation whi was within the mos Based on interview	ch was dated 01/12/24 which t recent twelve month period. at the time of record review, stor of Facilities agreed the			Staff and residents in the community have the potential be affected.	to	
	preparedness progra	am documentation was not ng reviewed within the most h period.			III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.	tic	
	_	he Maintenance Supervisor			There has been a new annual	I	

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PRINTED: 06/24/2024 FORM APPROVED OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/30/2024	
	PROVIDER OR SUPPLIE	R ID LIVING COMMUNITY		937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD WOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
					TELS task added for Janua every year to ensure the Emergency Manual is reviet and updated. See attached task labeled "E004 III. Gree Emergency Manual TELS T	wed I TELS enwood	
					IV The facility will monitor the corrective action by implementing the following measures.		
					CarDon Corporate facilities review this information during annual Corporate Quality R to ensure that the Emergen Disaster Manuals are up to	ng their eview cy	
					V. Plan of Correction completion date.  Plan of Completion date is a 18th, 2024.	June	
≣ 0006 SS=F Bldg	(1)-(2), 441.184(a 483.475(a)(1)-(2) (1)-(2), 485.625(a 485.727(a)(1)-(2) 486.360(a)(1)-(2) (1)-(2) Plan Based on Al §403.748(a)(1)-(2 §418.113(a)(1)-(2 §460.84(a)(1)-(2) §483.73(a)(1)-(2) §484.102(a)(1)-(2	416.54(a)(1)-(2), 418.113(a) 1)(1)-(2), 482.15(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a) 1)(1)-(2), 485.68(a)(1)-(2), 485.920(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a) I Hazards Risk Assessment 1), §416.54(a)(1)-(2), 1), §441.184(a)(1)-(2), 1), §483.475(a)(1)-(2), 1), §485.68(a)(1)-(2), 2), §485.727(a)(1)-(2),					

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	OF CORRECTION	IDENTIFICATION NUMBER  155412	UILDING	nstruction 	COMPI 05/30	ETED
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD WOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ATE	(X5) COMPLETION DATE
	§485.920(a)(1)-(2 §491.12(a)(1)-(2),	), §486.360(a)(1)-(2), §494.62(a)(1)-(2)				
	develop and main preparedness pla	lan. The [facility] must tain an emergency n that must be reviewed, ast every 2 years. The plan ving:]				
	' '	nd include a documented, community-based risk ing an all-hazards				
	· ,	gies for addressing s identified by the risk				
	Plan. The Hospice maintain an emer that must be revie	§418.113(a):] Emergency e must develop and gency preparedness plan wed, and updated at least e plan must do the				
	facility-based and assessment, utiliz approach.	nd include a documented, community-based risk ing an all-hazards jies for addressing				
	assessment, inclu the consequences disasters, and oth	s identified by the risk ding the management of s of power failures, natural er emergencies that would 's ability to provide care.				
	develop and main preparedness pla	s at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed, ast annually. The plan must				

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Facility ID: 000509

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f '			<u> </u>	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155412	B. WI	NG		05/30	/2024
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD  937 FRY RD  GREENWOOD, IN 46142				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment.  *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan modes are to a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment.  Based on record reversal failed to maintain a plan that was (1) based documented, facility risk assessment, utilized including missing restrategies for addressidentified by the risk with 42 CFR 483.73. In the Survey & Ce 19-06-ALL dated 0 Medicare and Medicare and Medicare and Medicare and Medicare and stated "Plannin approach should also described in the survey with the definant stated "Plannin approach should also described in the survey with the definant stated "Plannin approach should also described in the survey with the	ng missing residents.  gies for addressing s identified by the risk  [483.475(a):] Emergency must develop and maintain eparedness plan that must updated at least every 2 must do the following:  Ind include a documented, community-based risk ing an all-hazards	E 00	006	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 rist for Greenwood Health and Liv Furthermore, Infectious Disea was not included in the policy procedures at the community. The Administrator, DON, and Maintenance Supervisor have undated the all hazards risk	n / al sk ring. se and	06/18/2024

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	, ,	JILDING	NSTRUCTION	(X3) DATE S COMPLI 05/30/2	ETED	
	PROVIDER OR SUPPLIEI	R ID LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants.  Findings include:			assessment and reviewed the policy and procedure for successful. See attached E006 I				
	Based on review of Preparedness Manu 01/12/24 with the C during record revie on 05/30/24, the do community-based r infectious disease (zero percent. EID	The "Emergency Disaster relat" documentation dated Corporate Director of Facilities we from 12:00 p.m. to 1:10 p.m. cumented facility-based and risk assessment for emerging EID) threats was scored as was not included in the current			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 be affected.			
	preparedness progr facility. Based on in review, the Corpora emergency prepare did not address eme (EID) as part of the	ures section of emergency am documentation for the interview at the time of record ate Director of Facilities agreed dness program documentation erging infectious diseases facility-based and isk assessment as mandated			III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.  There has been a new annual			
	19-06-ALL.  These findings wer	we Certification memo QSO:  The reviewed with the the Maintenance Supervisor ference.			TELS task added for January every year to ensure the Emergency Manual is reviewe and updated. See attached T task labeled " E006 III. Green Emergency Manual TELS Tas	ed ELS wood		
					IV The facility will monitor the corrective action by implementing the following measures.			
					CarDon Corporate facilities wi review this information during annual Corporate Quality Rev to ensure that the annual risk assessment includes Infectiou Disease.	their iew		

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPLETED		
		155412	B. W	ING		05/30/	/2024	
	PROVIDER OR SUPPLIER	R ID LIVING COMMUNITY	•	937 FR	ADDRESS, CITY, STATE, ZIP COD LY RD NWOOD, IN 46142			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	OBE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					V. Plan of Correction completion date.			
					Plan of Completion date is Jur 18th, 2024.	ne		
E 0013 SS=F Bldg	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §466 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b).  (b) Policies and p develop and imple preparedness pol on the emergency (a) of this section, paragraph (a)(1) of communication pl section. The polici be reviewed and of years.  *[For LTC facilities and procedures. The procedures of the procedure of the proce	5(b), 483.475(b), 483.73(b), 425(b), 485.68(b), 420(b), 486.360(b), 4(b) EP Policies and Procedures 6.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 6.360(b), §491.12(b), 475(b), 625(b),						
	preparedness pol on the emergency (a) of this section, paragraph (a)(1) of	ement emergency icies and procedures, based / plan set forth in paragraph , risk assessment at of this section, and the an at paragraph (c) of this						

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section. The policies and procedures must be reviewed and updated at least annually.

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION IDENTIFICATION NUMBER  155412 B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2024				
	PROVIDER OR SUPPLIEI	RID LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD  937 FRY RD  GREENWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
	*Additional Requi ESRD Facilities:	rements for PACE and						
	procedures. The develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The policiaddress manager nonmedical emerlimited to: Fire; edialure; care-relatedisasters likely to safety of the parti. The policies and previewed and upon the emergency (a) of this section paragraph (a)(1) communication pl section. The policies and procedures. develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The policies and procedures are mot limited to, fire failures, care-relas supply interruption likely to occur in tarea.	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. procedures must be lated at least every 2 years.  Ities at §494.62(b):] Policies The dialysis facility must ement emergency icies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 ergencies include, but are a equipment or power ted emergencies, water and natural disasters the facility's geographic						
		view and interview, the facility	E 00	013	The corrective actions to I     accomplished for those	oe	06/18/2024	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/30/2024			
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD  937 FRY RD  GREENWOOD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
PREFIX	regulatory of preparedness policipolicies and proceddiseases (EID). The previewed and up accordance with 42 practice could affect in the procedure of preparedness Manu 01/12/24 with the Couring record reviewed on 05/30/24, emergorocedures addressive review. Based on it review, the Corporate mergency prepared addressing EID was the procedure on 05/30/24.	es and procedures to include ures for emerging infectious e policies and procedures must dated at least annually in CFR 483.73(b). This deficient et all occupants.  The "Emergency Disaster all" documentation dated Corporate Director of Facilities w from 12:00 p.m. to 1:10 p.m. ency preparedness policies and ing EID was not available for interview at the time of record ate Director of Facilities agreed dness policies and procedures is not available for review.	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE  n  y al isk ving. ise and		
				place the following systema changes to ensure that the deficient practice does not recur.  There has been a new annua	I		
				TELS task added for January every year to ensure the Emergency Manual is reviewed.			

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CENTERS FO	OMB NO. 0938-039				
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (	X3) DATE SURVEY COMPLETED 05/30/2024
	PROVIDER OR SUPPLIEF	D LIVING COMMUNITY	937 FF	ADDRESS, CITY, STATE, ZIP COD RY RD NWOOD, IN 46142	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				and updated. See attached TE task labeled " E013 III. Greenwood Emergency Manua TELS Task"	ELS
				IV The facility will monitor the corrective action by implementing the following measures.	
				CarDon Corporate facilities will also review this information dur their annual Corporate Quality Review to ensure that the annurisk assessment includes Infectious Disease.	ing
				V. Plan of Correction completion date.	
				Plan of Completion date is June 18th, 2024.	Э
E 0041 SS=F Bldg	§482.15(e) Condii (e) Emergency an The hospital must standby power sy emergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485.	LTC Emergency Power tion for Participation: ad standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and set forth in paragraphs (b)(1) section.			
		d standby power systems. and the CAH] must			

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implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.

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	OF CORRECTION	IDENTIFICATION NUMBER  155412	A. BUILDING B. WING	onstruction 	COMI	E SURVEY PLETED 0/2024		
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD  937 FRY RD  GREENWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	Emergency generator must be the location requirements To structure or building the lospital, CAP implement the eminspection, testing requirements foun Facilities Code, NICode.  482.15(e)(2), §483 Emergency generating the lospital, CAP implement the eminspection, testing requirements foun Facilities Code, NICode.  482.15(e)(3), §483 Emergency generating and LTC facilities source to power end LTC facilities source to power end a plan for hopower systems opemergency, unless *[For hospitals at §483.73(g), and CThe standards incomplement the Efederal Register in 552(a) and 1 CFR	e located in accordance with ements found in the Health de (NFPA 99 and Tentative nts TIA 12-2, TIA 12-3, TIA dd TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, dd NFPA 110, when a new rewhen an existing ng is renovated.  3.73(e)(2), §485.625(e)(2) ator inspection and testing. Health Care FPA 110, and Life Safety din the Health Care FPA 110, and Life Safety  3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs that maintain an onsite fuel mergency generators must wit will keep emergency the accurates.  §482.15(h), LTC at the Safety of the opposed for incorporation by Director of the Office of the on accordance with 5 U.S.C. part 51. You may obtain the sources listed below.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155412		A. BUILDING B. WING		COM	COMPLETED 05/30/2024	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZII Y RD NWOOD, IN 46142	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	Information Resource Boulevard, Baltimo Archives and Reco (NARA). For information this material at NA go to:  http://www.archive_of_federal_regular in the federal_regular incorporated by redocument in the Federal and the federal federal federal federal incorporated by redocument in the Federal	rice Center, 7500 Security ore, MD or at the National ords Administration nation on the availability of IRA, call 202-741-6030, or is gov/federal_register/code ations/ibr_locations.html. this edition of the Code are ference, CMS will publish a ederal Register to inges. rotection Association, 1 Kg., www.nfpa.org, the Care Facilities Code, ed August 11, 2011. Im amendment (TIA) 12-2 to August 11, 2011. IPA 99, issued August 9, IPA 99, issued August 1, IPA 99, issued August 1, IPA 99, issued August 1, IPA 99, issued March 3, IPA 99, issued 99, IPA				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY  COMPLETED  05/30/2024			
	PROVIDER OR SUPPLIEI	RID LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE)	TE	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	REGULATORY OF including TIAs to 2009  Based on observation failed to implement inspection, testing a found in the Health 110, and Life Safet CFR 483.73(e)(2). affect all residents,  Findings include:  Based on observation of the facility at 8:55 a.m. POWER" indicator on the facility's wal generator annuncian nurse's station. Base the observations, the stated the emergence running, the generate the light should have transferred back to The Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supower could be transferred based on observation the Maintenance Supow	chapter 7, issued August 6, on and interview, the facility the emergency power system and maintenance requirements Care Facilities Code, NFPA by Code in accordance with 42 This deficient practice could		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 wailluminated indicating that the generator was running and it wonot. Part has been ordered ar 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 be affected.  III. The facility will put into place the following systematic changes to ensure that the deficient practice does not	oe n as was nd e		
	Based on interview observations, the Mathematical the contractor was the annunciator par which required a di	<del>-</del>		recur.  The Maintenance Supervisor has been re educated to inspect the interior generator annunciator panel during his weekly run te	ne		

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reprogramming the panel.

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to ensure the proper lights are

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  05/30/2024	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DATE		
	These findings were Administrator and t during the exit conf	he Maintenance Supervisor			illuminated. See attached E04 III.  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities wi also review the generator annunciator during their annual Corporate Quality Review to ensure that the appropriate ligare illuminated.  V. Plan of Correction completion date.  Plan of Completion date is Jun 18th, 2024.	ill al yhts	
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 05/30  Facility Number: 0 Provider Number: 1002  At this Life Safety 0 Health And Living	00509 155412	K 0	000	This letter is to inform you that plan of correction attached is serve as Greenwood Health at Livings credible allegation of compliance. We allege substantial compliance on Jur 18, 2024. We are requesting paper compliance for this plan correction.  Submission of this plan of correction in no way constitute an admission by Greenwood Health and Living or its management company that the	to and ne n of	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE COMPL 05/30	ETED
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FF	ADDRESS, CITY, STATE, ZIP CO RY RD NWOOD, IN 46142	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupation This one story facility Type V (111) const. The facility has a findetection in the corresponding to the corridor. The facility a census of 98 at the All areas where resist were sprinklered. T	dents have customary access the facility has two detached facility storage services nklered.		allegations contained in report is a true and acceportrayal of the provision care or other services of this facility. The Plan of Correction is prepared executed solely because required by Federal and Law.  This statement of deficiplan of correction will be at the Monthly Quality Assurance/Assessment Committee meeting.	urate on of nursing orovided in of and se it is d State dencies and e reviewed	
K 0363 SS=E Bldg. 01	than required enclexits, or hazardou of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. T	rials have positive latching atches are prohibited by hese requirements do not spaces that do not contain				

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ	A. BUILDING <u>01</u> COM			ATE SURVEY MPLETED	
		155412	B. WI	NG		05/30/	/2024	
	PROVIDER OR SUPPLIE	R ND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD  937 FRY RD  GREENWOOD, IN 46142					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG	Clearance betwee covering is not ex doors complying if provided with a the door closed wapplied. There is closing of the door release when the permitted. Nonrat unlimited height a meeting 19.3.6.3. frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. I there are no restriction resistance of glass assemblies.  19.3.6.3, 42 CFR 483, and 485 Show in REMARI fire protection rational devices, etc. Based on observating failed to ensure 1 or resident sleeping reclosing and latchin would resist the papractice could affer visitors in the vicing 517.  Findings include:  Based on observating the Maintenance St. Director of Facilities.	en bottom of door and floor acceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the ors. Hold open devices that door is pushed or pulled are red protective plates of are permitted. Dutch doors 6 are permitted. Door abeled and made of steel or compliance with 8.3, a compartment is a fire window assemblies are in sprinklered compartments ictions in area or fire as or frames in window.  Parts 403, 418, 460, 482,  KS details of doors such as ngs, automatics closing  on and interview, the facility of over 60 corridor doors to boms had no impediment to go into the door frame and assage of smoke. This deficient ent over 10 residents, staff and an interview of resident sleeping Room  ons with the Administrator, apervisor and the Corporate residenting a tour of the facility staff p.m. on 05/30/24, the	K 0:	TAG 363	I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation 1– The Commun failed to ensure that resident into the door frame. The Maintenance Supervisor has reworked the door so it will late properly into the door frame. Supervisor has reworked the door frame.	n nity room perly	06/18/2024	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE C A. BUILDING B. WING	construction 01	(X3) DATE SURVEY  COMPLETED  05/30/2024			
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	REGULATORY OR latching mechanism resident sleeping Ro the latching plate or prevented the corriclatching into the domultiple times. Bas the observations, the agreed the corridor Room 517 had an inlatching into the dot the passage of smoken.	a LSC IDENTIFYING INFORMATION on the corridor door to com 517 failed to protrude into n the door frame which dor door from fully closing and or frame when tested to close sed on interview at the time of the Maintenance Supervisor door to resident sleeping mpediment to closing and or frame and would not resist the. The reviewed with the the Maintenance Supervisor		CROSS-REFERENCED TO THE APPROPRI	e itic  LS t led " Door  fill eir view		
				the community shut and latch properly.  V. Plan of Correction completion date.  Plan of Completion date is Ju			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE ( A. BUILDING	(X3) DATE SURVEY COMPLETED				
		155412	B. WING 05/30/2024				
	ROVIDER OR SUPPLIER	D LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD  937 FRY RD  GREENWOOD, IN 46142				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE		
K 0372 SS=E Bldg. 01	Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be postriers shall be postriers shall be postrium wall. Smoke in duct penetration systems where an is installed for smote to the smoke barrier system in REMAR Based on observation failed to ensure 1 of protected to maintain the smoke barrier work requires	all be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an ele dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.  ) hanical smoke control eKS.  on and interview, the facility is 8 smoke barrier walls were in the fire resistance rating of all. LSC Section 19.3.7.5 iers to be constructed in in C Section 8.5 and shall have a re resistive rating. This ould affect over 20 residents, the vicinity of the corridor od.	K 0372	I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation 1– The Commun failed to ensure that the fire subarrier wall near resident room maintained a consistent fire rating. 3 separate holes were found in the smoke barrier was The Maintenance Supervisor patched these penetrations. attached pictures showing the areas sealed and corrected K	n sity moke m 504 stall. has See ese		
	from 1:35 p.m. to 3:15 p.m. on 05/30/24, three			1.			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 05/30/2024			
	PROVIDER OR SUPPLIER	RID LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 937 FRY RD GREENWOOD, IN 46142					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	barrier wall above to 504. The attic smool ayer of 5/8th's inched the wall stud. The surrounding a four sprinkler pipe which inched by one inched wall by the sprinkle cables through the diameter open ende	enoted in the attic smoke the corridor door set by Room ke barrier wall consisted of one at thick drywall on each side of tholes were the annular space inch in diameter horizontal the penetrated the wall, a three tetangular shaped hole in the ter pipe for the passage of data wall and a three inch in the digray conduit also for the		II. The facility will identify other residents that may potentially be affected by the deficient practice.  Staff and residents near 500 have the potential to be affected.	n <b>e</b> ) hall			
	door in the corridor equipped with a 20 label on the door ar door frame when te interview at the tim Maintenance Super aforementioned operabove the corridor of firestopped to main the smoke barrier w	enings in the smoke barrier wall door set by Room 504 were not tain the fire resistance rating of vall.  e reviewed with the the Maintenance Supervisor		III. The facility will put into place the following systems changes to ensure that the deficient practice does not recur.  Observation 1- There is a TE task to inspect all smoke bar every 6 months to ensure that there are no open penetration See attached TELS task laber K372 III. Greenwood Smoke Barrier Inspection TELS Task	ELS riers at ns. eled "			
	3.1-19(b)			IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities vinspect these areas during the annual Corporate Quality Reto ensure there are no open penetrations.  V. Plan of Correction	vill neir			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155412	B. W	ING		05/30/	/2024
	PROVIDER OR SUPPLIEI	I R ID LIVING COMMUNITY		937 FR	ADDRESS, CITY, STATE, ZIP COD Y RD IWOOD, IN 46142		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
					completion date.		
					Plan of Completion date is Jur 18th, 2024.	1e	
K 0741 SS=D Bldg. 01	shall include not le provisions:  (1) Smoking shall ward, or compartr liquids, combustibused or stored an location, and such signs that read Not posted with the insmoking.  (2) In health care smoking is prohibused prominently place secondary signs was smoking shall not (3) Smoking by paresponsible shall (4) The requirement apply where the pare supervision.  (5) Ashtrays of not safe design shall where smoking is (6) Metal contained devices into which	be prohibited in any room, ment where flammable ole gases, or oxygen is d in any other hazardous in area shall be posted with O SMOKING or shall be ternational symbol for no occupancies where ited and signs are id at all major entrances, with language that prohibits be required. Items classified as not be prohibited. Items of 18.7.4(3) shall not patient is under direct oncombustible material and the provided in all areas permitted. Items with self-closing cover in ashtrays can be emptied vailable to all areas where					

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Based on observation and interview, the facility

failed to ensure smoking materials were deposited

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I. The corrective actions to be

accomplished for those

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155412	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 05/30/2024
	PROVIDER OR SUPPLIEI	R ID LIVING COMMUNITY	937 FF	ADDRESS, CITY, STATE, ZIP COD RY RD NWOOD, IN 46142	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  DESCRIPTION OF THE OPEN ATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULL CROSS-REFRENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION
TAG	into ashtrays and m self-closing cover of can be emptied of m safe design in 1 of was taking place. If affect over 2 staff.  Findings include:  Based on observation the Maintenance Staff Director of Facilities from 1:35 p.m. to 3 cigarette butts were enclosed in a open sided trash can locate the service hall exist container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place. If of the observations stated the area was agreed a metal container with self-provided at this out was taking place.	e reviewed with the the Maintenance Supervisor	TAG	residents found to have to affected by the deficient practice.  Observation 1– The communication failed to ensure that the sensure that the sensure that the sensure disposal can onservate deficient practice.  Residents and associates the potential to be affected by deficient practice does not recur.  The facility will put interpolate the following system changes to ensure that the deficient practice does not recur.  The Administrator has reservate associates that our sensure that all associates smoke in their vehicles.  IV The facility will monitate corrective action by implementing the following measures.	nunity noke sing proper ite. The s  ify  the  have I.  to matic ne ot  educated oking s must  tor
				CarDon Corporate Facilitie inspect these areas during annual Corporate Quality F	their

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	ND PLAN OF CORRECTION  IDENTIFICATION NUMBER  155412		A. BUILDING 01  B. WING		COMPLETED 05/30/2024	
	PROVIDER OR SUPPLIER	D LIVING COMMUNITY	937 FR	ADDRESS, CITY, STATE, ZIP COD XY RD NWOOD, IN 46142		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				to ensure that the facility rema a smoke free campus.  V. Plan of Correction completion date.  Plan of Completion date is Jun 18th, 2024.		
K 0916 SS=F Bldg. 01	Electrical Systems System Alarm Ann A remote annuncia powered is provide generating room ir observed by opera annunciator is hard conditions of the e centralized comput information system for the alarm annu 6.4.1.1.17, 6.4.1.1 Based on observation failed to ensure 1 of annunciator panels of condition. This defir residents, staff and of Findings include:  Based on observation Supervisor during the facility at 8:55 a.m. POWER" indicator on the facility's wall	ator that is storage battery ed to operate outside of the n a location readily ating personnel. The d-wired to indicate alarm mergency power source. A ter system (e.g., building n) is not to be substituted nciator.	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 we illuminated indicating that the generator was running and it to not. Part has been ordered and	as was	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLI	ETED	
		155412	B. W	ING		05/30/2	2024	
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIE	R		937 FR				
CDEENIV	VOOD HEALTH AA	ID LIVING COMMUNITY			NWOOD, IN 46142			
GNEENV	VOOD HEALTH AN	ND LIVING COMMONT I		GKEEN	NVOOD, IN 40142			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTI			(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE	
	nurse's station. Bas	sed on interview at the time of			part has been scheduled to be	э		
	the observations, th	ne Maintenance Supervisor			repaired.			
	stated the emergency generator is not currently							
		tor was running last week and			II. The facility will identify			
	1	ve gone off once power was			other residents that may			
		the normal source last week.			potentially be affected by the	e		
		Supervisor stated building			deficient practice.			
	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,							
					Staff and residents in the			
					community have the potential	to		
					be affected.			
	the Maintenance Supervisor and the Corporate							
	Director of Facilities during a tour of the facility							
	_	:15 p.m. on 05/30/24, the "GEN			III. The facility will put into			
		s still illuminated in yellow.			place the following systemat	tic		
	Based on interview				changes to ensure that the			
		faintenance Supervisor stated			deficient practice does not			
		currently on site for repairs but			recur.			
	_	nel needed to be reprogrammed						
		fferent contractor to come on			The Maintenance Supervisor			
		who was more familiar with			been re educated to inspect the			
	reprogramming the	panel.			interior generator annunciator			
		· a sala			panel during his weekly run te			
	_	e reviewed with the			to ensure the proper lights are			
		the Maintenance Supervisor			illuminated. See attached K91	6		
	during the exit conf	terence.			l III.			
	3.1-19(b)				IV The facility will magaite			
	3.1-19(0)				IV The facility will monitor			
					the corrective action by implementing the following			
					measures.			
					ilicasules.			
					CarDon Corporate facilities wi	iii		
					also review the generator	"		
					annunciator during their annua	<sub>al</sub>		
					Corporate Quality Review to	~		
					ensure that the appropriate lig	<sub>ihts</sub>		
					are illuminated.	,		
					a.c marimatou.			
					V. Plan of Correction			

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER  155412	A. BUILDING 01  B. WING		COMPLETED 05/30/2024			
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
K 0920 SS=E	NFPA 101 Electrical Equipme	ent - Power Cords and		completion date.  Plan of Completion date is Jur 18th, 2024.	ne			
Bldg. 01	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.				

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Event ID:

Z3DZ21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/30/2024 155412 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 937 FRY RD GREENWOOD HEALTH AND LIVING COMMUNITY GREENWOOD, IN 46142 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Electrical Code, 2011 Edition. NFPA 70, Article Observation - The community 400.8 requires that, unless specifically permitted, failed to ensure that all appliances flexible cords and cables shall not be used as a within the community were substitute for fixed wiring of a structure. LSC plugged into appropriate outlets. Section 4.5.7 states any building service There was a power strip in the equipment or safeguard provided for life safety admissions office with a coffee shall be designed, installed and approved in pot, microwave, and refrigerator accordance with all applicable NFPA standards. plugged into it. The Maintenance This deficient practice could affect over 10 Supervisor has added a double residents, staff and visitors in the vicinity of the outlet for the small appliances. Marketing Director's office near the main entrance See attached K920 I. lobby. II. The facility will identify Findings include: other residents that may potentially be affected by the Based on observations with the Administrator, deficient practice. the Maintenance Supervisor and the Corporate Director of Facilities during a tour of the facility Staff and residents in the from 1:35 p.m. to 3:15 p.m. on 05/30/24, a marketing office area have the refrigerator, a microwave oven and a coffee maker potential to be affected. 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 III. The facility will put into the observations, the Administrator, the place the following systematic Maintenance Supervisor and the Corporate changes to ensure that the Director of Facilities agreed a power strip was deficient practice does not being used as a substitute for fixed wiring at the recur. aforementioned location. The Maintenance Supervisor has These findings were reviewed with the been re educated on the use of Administrator and the Maintenance Supervisor power strips and small during the exit conference. appliances. An every 3 month TELS task was created to inspect 3.1-19(b) 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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155412		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/30/2024			
NAME OF PROVIDER OR SUPPLIER  GREENWOOD HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP COD  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		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
					IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities wi also inspect the entire commuduring their annual Corporate Quality Review to ensure that Appliances and power strips a use correctly.  V. Plan of Correction completion date.  Plan of Completion date is Jun 18th, 2024.	inity		

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