STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155788	A. BUILDING -- B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N STATE ROAD 135 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: 11/17/22 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Emergency Preparedness survey, Greenwood Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 169 certified beds. At the time of the survey, the census was 134. Quality Review completed on 11/21/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/17/22 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Life Safety Code survey, Greenwood Meadows was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
R. Shane McFall	Executive Director	12/07/2022

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

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and 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 smoke detectors hardwired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 169 and had a census of 134 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/21/22			
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			

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	flammable or combustible material. 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 4 of over 50 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 40 residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Administrator in Training during a tour of the facility from 12:20 p.m. to 2:40 p.m. on 11/17/22, the	K 0363	A. Doors for patient rooms 107, 108, 120, 210 were adjusted to latch at closure 11-30-2022. B. All doors within facility were checked for latch at closure 11-17-2022. C. An audit was completed on 11-17-2022 of all doors in the facility and ensured that all closed and latched. An inservice was completed with Maintenance and Housekeeping departments on the requirement of latching, and handling doors that don't latch	12/09/2022

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	corridor door to resident sleeping Room 107, Room 108, Room 120 and Room 210 each failed to latch into the door frame when tested to close multiple times. The latching mechanism for each corridor door failed to protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. This finding was reviewed with the Executive Director, the Maintenance Director and the Administrator in Training during the exit conference. 3.1-19(b)		with workorder and adjustment. D. Preventative maintenance checklist will be utilized to ensure facility doors are in proper working order. Results of those checklists will be reviewed monthly at QAPI meeting for 6 months, then quarterly thereafter. Any issues arising from the checklists will be handled through Corrective Action Plan managed by the QAPI team.	
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 9 smoke barrier walls were protected to maintain the fire resistance of the smoke barrier. LSC Section 19.3.7.5 requires	K 0372	A. Breach in the fire wall was corrected on 11-17-2022. B. All other fire walls were inspected for breaches on	12/09/2022

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	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 all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Administrator in Training during a tour of the facility from 12:20 p.m. to 2:40 p.m. on 11/17/22, a three inch in diameter hole was noted in the smoke barrier wall in the attic above the corridor door set by Room 508 and Room 509. The hole was near the center of the wall just above PVC sprinkler piping in the attic. The attic was accessed from the attic access door in the Therapy Room. In addition, a one inch in diameter hole for the the passage of two green data cables and one blue data cable was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by Room 508 and Room 509. Each hole was not firestopped to maintain the fire resistance of the smoke barrier. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned openings in the smoke barrier wall were not firestopped to maintain the fire resistance of the smoke barrier. This finding was reviewed with the Executive Director, the Maintenance Director and the Administrator in Training during the exit conference. 3.1-19(b)		11-24-2022. C. An audit of fire walls were inspected for breaches. Inservice training was provided to Maintenance personnel to follow-up contractors worksites for new beaches in fire walls. D. Preventative maintenance checklist will be utilized to ensure no breaches in fire walls. The results of those preventative maintenance checklists will be reviewed monthly for 6 months at QAPI meeting, then quarterly thereafter. Any issues arising from the checklists will be handled through Corrective Action Plans managed by the QAPI team.	
K 0761 SS=F Bldg. 01	Based on record review, observation and	K 0761	A. 18 additional doors to	12/09/2022

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	interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.		hazardous areas as defined in K761 were added to the list of Fire Doors and an inspection was completed for each. B. 18 additional doors to hazardous areas as defined in K761 were added to the list of Fire Doors and an inspection was completed for each. C. An inservice was completed with maintenance personnel on the new 2016 requirements for identifying fire doors and inspections that follow. D. Preventative Maintenance checklist will be utilized to ensure that Fire Doors are properly identified and inspected by regulation and policy. Results of those checklists will be reviewed monthly for 6 months at QAPI meeting, thereafter quarterly. Any issues arising from checklists will be handled through Corrective Action Plans managed by the QAPI committee.	

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	(4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Annual Inspection of Swinging Fire Door Assemblies" documentation and Direct Supply TELS fire door inspection documentation dated 01/25/22, annual inspection documentation of fire door assemblies in the facility within the most recent twelve month period did not include all fire doors in the facility. The annual inspection documentation dated 01/25/22 included cross corridor door sets in the 100 Wing through the 500 Wing and the oxygen storage and transfilling room. The annual inspection documentation did not include hazardous areas in the facility which were constructed prior to 2016 and did not include all fire doors in the facility. Based on observations with the Executive Director, the Maintenance Director and the Administrator in Training during a tour of the facility from 12:20 p.m. to 2:40 p.m. on			

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	11/17/22, entry room doors to over 10 hazardous areas such as fuel fired heater rooms, laundries larger than 100 square feet, soiled linen and trash collection rooms, physical plant maintenance shops and storage rooms larger than 100 square feet used for storing combustible material and kitchens were noted in the facility. Each entry door to the rooms was a fire-rated door with a minimum 1-hour fire resistance rating label affixed to the door. Based on interview at the time of record review and of the observations, the Maintenance Director agreed it could not be ensured all fire door locations in the facility were included in the most recent annual fire door inspection documentation. This finding was reviewed with the Executive Director, the Maintenance Director and the Administrator in Training during the exit conference. 3.1-19(b)			