STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155788	A. BUILDING 01 B. WING	01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/14/16 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Life Safety Code survey, Greenwood Meadows was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New 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	K 0000	Thecreation and submission of this Plan of Correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation. This provider respectfully requests that the2567 Plan of Correction be considered the Letter of Credible Allegation toverify substantial compliance for this deficiency on February 13, 2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	rooms. The facility has a capacity of 169 and had a census of 153 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 01/19/16 - DA			
K 0048 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2. (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents, staff and visitors in the event of	K 0048	**K 048 FIRE SAFETY PLAN** **What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?** ·Noresidents were affected by the alleged deficient practice. **How will you identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** ·Allresidents have the potential to be affected by the alleged deficient practice. ·Thewritten health care fire safety plan and corresponding floor plan will beupdated by the Maintenance Director and Executive Director to identify whichcorridor doors are fire doors	02/13/2016

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	an emergency. Findings include: Based on review of "Disaster Preparedness" documentation with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 01/14/16, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. Section E.1a "Fire/Explosion Emergency Action Plan" of the aforementioned written fire safety plan stated "Keep all smoke/fire doors closed". Under Section 1.b "Fire Procedure" states "Continue moving in sequence all people in the area until all are past the fire compartment doors. Do not go back through fire doors". Based on interview at the time of record review, the Maintenance Director stated all doors in the facility are smoke barrier doors but acknowledged the location of fire doors and smoke barrier doors for smoke compartment evacuation are not identified in the written fire safety plan for the facility for evacuation purposes. 3.1-19(b)		and which are smoke barrier doors. In addition, each fire and smoke barrier doorwill be clearly labeled as to their identity. ·Educationwill be provided to staff by Maintenance Director/Designee on an on-going basisduring all staff meetings, orientation and at fire drills to ensure compliance. **What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur?** ·Thewritten health care fire safety plan and corresponding floor plan will beupdated by the Maintenance Director and Executive Director to identify whichcorridor doors are fire doors and which are smoke barrier doors. In addition, each fire and smoke barrier doorwill be clearly labeled as to their identity. ·Educationwill be provided to staff by Maintenance Director/Designee on an on-going basisduring all staff meetings, orientation and at fire drills to ensure compliance. **How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?** ·Toensure compliance the Maintenance Director will monitor the fire safety planupdates and staff education on the Fire Safety CQI audit tool quarterly. Findings	

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			will be forwarded to the SafetyCommittee and CQI team for review. Afterone year, the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result indisciplinary action up to and including termination of the responsibleemployee.	