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	02/09/2017

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: 02/09/17 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Life Safety Code survey, Greenwood Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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	K 0000	F000 This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUEST A DESK REVIEW IN LIEU OF POSTSURVEY REVIEW on or after February 21, 2017.	

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

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	and had a census of 157 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 02/13/17 - DA			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Clean Laundry rooms were only held open by a release device complying with LSC 7.2.1.8.2 that automatically closes such doors upon activation of the fire alarm system. This deficient practice	K 0223	**K223 NFPA 101 Doors with Self Closing Devices** **Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous are enclosure are self-closing**	02/21/2017

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	could affect 28 residents staff and visitors if needing to exit the facility from the service corridor. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 02/09/17, the corridor door to the Clean Laundry room in the service corridor was propped in the fully open position with a wedge placed on the floor under the door. The Clean Laundry room measured greater than 100 square feet in size. The service corridor was marked as a facility exit for the 300 Hall by Room 314. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the aforementioned hazardous area was held open with a wedge placed on the floor. 3.1-19(b)		**and kept in the closed position.** ·The corridor door to the clean laundry room was propped open with a wedge. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·On 2/9/17, The Maintenance Director removed wedge in door and provided education to staff. On 2/10/17 House Keeping Director provided in-service to Housekeeping/ Laundry team on the importance of not propping open self-closing doors. 2/10/17 Sign was placed on back of door advising “Do not prop doors”. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** . ·Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	

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			practice does not recur? ·Housekeeping Director will ensure doors to laundry room are closed and not propped open. In addition, inspected periodically then verified by the Executive Director. Any concerns will be addressed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Housekeeping Director will review with ED monthly during Safety Meeting. If 100% threshold is not achieved, an action plan will be developed.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.			

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	19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to ensure 1 of 17 hazardous areas such as laundries greater than 100 square feet in size were separated from other spaces by smoke resistant partitions. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 28 residents staff and visitors if needing to exit the facility from the service corridor. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 02/09/17, the corridor door to the Clean Laundry room in the service corridor was propped in the fully open position with a wedge placed on the floor under the door. The Clean Laundry room measured	K 0321	**K321 NFPA 101Hazardous Areas- Enclosure** **Hazardous areas are protected by a fire barrier having 1-hour fire resistance or an automatic fire extinguishing system in accordance with 8.7.1. When approved automatic fire extinguishing system is used, the areas shall be separated from other spaces by smoke resisting partitions and doors with accordance with 8.4.** ·The corridor door to the clean laundry room was propped open with a wedge. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	02/21/2017

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	greater than 100 square feet in size. The service corridor was marked as a facility exit for the 300 Hall by Room 314. Based on interview at the time of observation, the Maintenance Director acknowledged the use of the wedge for the corridor door failed to allow the door to self close and latch into the door frame and failed to separate this hazardous area from other spaces by smoke resistant partitions. 3.1-19(b)		**practice?** ·On 2/9/17, The Maintenance Director removed wedge in door and provided education to staff. On 2/10/17 Executive Director provided in-service to Housekeeping team on the importance of not propping open self-closing doors to the laundry room. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** . ·Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Housekeeping Director will ensure doors to laundry room are closed and not propped open. In addition, inspected periodically then verified by the Executive Director. Any concerns will be addressed immediately. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place? ·Housekeeping Director will review with ED monthly during Safety Meeting. If 100% threshold is not achieved, an action plan will be developed.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected	K 0353	**K353 NFPA 101 Sprinkler System- Maintenance and Testing** **Automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, standard for the Inspection, Testing, and Maintaining of Water- based**	02/21/2017

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	monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of P.I.P.E.'s "Report of Inspection" documentation dated 04/06/16, 07/21/16, 10/24/16 and 01/27/17 with the Maintenance Director during record review from 9:10 a.m. to 11:20 a.m. on 02/09/17, weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 week period was not available		**Fire Protection Systems.** **·Weekly Dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 weeks was not available for review.** **·Monthly wet sprinkler system gauge inspection documentation for 8 months of the most recent 12 months' period was not available for review.** **·Monthly inspection documentation for all sprinkler system control valves for 8 months of most recent 12 months was not available for review.** **·The Facility failed to ensure that 6 of 6 sprinkler system gauges were replaced every five years or documented as tested every five years by comparison to calibrated gauge.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Maintenance Director to inspect and track weekly using Weekly Gauge Inspection Sheet for DRY Automatic Fire Sprinkler Systems. ·Maintenance Director to inspect and track Monthly using Monthly Gauge Inspection Sheet	

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	for review. Monthly wet sprinkler system gauge inspection documentation for 8 months of the most recent 12 month period was also not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility does not document additional sprinkler system gauge and system control valves inspections and acknowledged sprinkler system gauge and control valve inspection documentation for the aforementioned weekly and monthly periods was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 02/09/17, the facility has supervised dry and wet sprinkler systems and had a total of six and water pressure gauges. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 6 of 6 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance		for WET Automatic Fire Sprinkler Systems. · Maintenance Director to inspect and track Monthly using Monthly Valve Inspection Sheet for Automatic Fire Sprinkler Systems. ·Contractor visited and building and replaced six sprinkler system gauges on February 20, 2016. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·Residents currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Maintenance Director to inspect and track weekly using Weekly Gauge Inspection Sheet for DRY Automatic Fire Sprinkler Systems. ·Maintenance Director to inspect and track Monthly using Monthly Gauge Inspection Sheet for WET Automatic Fire Sprinkler Systems. · Maintenance Director to	

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	of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 02/09/17, the facility has supervised dry and wet sprinkler systems and had a total of three six and water pressure gauges. The manufacture date of 2010 was listed on the face of each sprinkler system gauge. No recalibration date information was affixed to the sprinkler system gauges. Based on interview at the time of the observations, the Maintenance Director stated he did not believe sprinkler system gauges had been recalibrated within the most recent five year period and acknowledged documentation of sprinkler system gauge replacement or recalibration was not available for review for each of 6 sprinkler system gauges which were more than five years old.		inspect and track Monthly using Monthly Valve Inspection Sheet for Automatic Fire Sprinkler Systems. ·Contractor visited and building and replaced six sprinkler system gauges on February 20, 2016. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Director will maintain the Maintenance PM Schedule to verify all Weekly, Monthly, Quarterly, Semi Annual, Annul, Every Two Years and Every Five Years Inspections are completed. Maintenance Director will review this checklist with Executive Director monthly during safety meeting.	

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	3.1-19(b)			
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 openings through 1 of 17 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the	K 0372	**K372 NFPA 101 Subdivision of Building Spaces- Smoke Barrier Construction** **Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. The facility failed to ensure the opening through 1 of the 17 smoke barrier (wall above the corridor door set by room 304 on 300 Hall) was protected to maintain the fire resistance rating of the smoke barrier.** .	02/21/2017

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	requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect 28 residents, staff and visitors in the 300 Hall. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 02/09/17, a four inch by three inch hole for the passage of one data cable was noted in the attic smoke barrier wall above the corridor door set by Room 304 in the 300 Hall. The aforementioned attic smoke barrier wall consisted of four layers of five eighths inch thick drywall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned hole in the attic smoke barrier wall failed to maintain the fire resistance rating of the smoke barrier. 3.1-19(b)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·On 2/20/2017, the Maintenance Director covered and sealed the 2-inch x 3-inch hole for ten cables with a fire stop caulking the smoke barrier wall above the corridor door set by room 304 on the 300 Hall. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** . ·This deficient practice could affect residents, staff and visitors in the vicinity of the door set by room 304 0n the 300 Hall. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Maintenance Supervisor will ensure that required smoke barrier walls are compliant with code. Systems are continuously	

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			maintained in reliable operating condition and are inspected periodically then verified by the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Maintenance Director will inspect each Fire Barrier quarterly and update as needed. Maintenance will track Quarterly with Fire Barrier Maintenance Checklist Tracking Tool to ensure barriers are in compliance. Maintenance Director will review with ED monthly during Safety Meeting. If 100% threshold is not achieved, an action plan will be developed	