

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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	<p>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).</p> <p>Survey Date: 07/14/16</p> <p>Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860</p> <p>At this Life Safety Code survey, Wintersong Village was found not in 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 48 and had a census of 31 at the time of this survey.</p>	K 0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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 0025 SS=F Bldg. 01	<p>All areas where residents have customary access were sprinklered. All areas providing facility services.</p> <p>Quality Review completed on 07/19/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed</p>	K 0025	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the surveyreport. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p> <p>K025 Corrective action for residents affected: No residents were affected by this alleged negative practice, the penetrations through 3 of 3 smoke</p>	08/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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 0029 SS=D Bldg. 01	<p>for the specific purpose. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 07/14/16 between 11:37 a.m. and 11:40 a.m., the following attic smoke barrier unsealed penetrations were discovered:</p> <ul style="list-style-type: none"> <li>a. one sixteenth of an inch around two cables in smoke barrier #1</li> <li>b. three eighths of an inch around a cable in smoke barrier #2</li> <li>c. three eighths of an inch around a cable in smoke barrier #3</li> </ul> <p>Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with</p>		<p>barrier walls of the laundry were sealed with fire rated caulk.</p> <p>Other residents' affected and corrective action: No residents were affected by this allegednegative practice, the penetrations through 3 of 3 smoke barrier walls of thelaundry were sealed with fire rated caulk.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated ofthe requirements of using a fire rated caulk to seal penetrations. All otherareas of the facility were inspected with no areas of concern noted.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitorby conducting facility rounds and observing wall penetrations during monthlypreventative maintenance rounds, any negative findings will be reported to theAdministrator and will be corrected immediately. Monthly preventative maintenance monitoringwill be reviewed during the facilities Quality Assurance meeting as a means ofcontinued compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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
	<p>8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Kitchen room, a hazardous area, did not have an impediment to latching. This deficient practice could affect at least 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/14/16 at 11:23 a.m., the Kitchen room contained fuel fired appliances. The dining room door in the Kitchen room had a door stop installed on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that staff use the door stop for ease of use.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Laundry room, a hazardous area, would latch into the frame. This deficient practice was not in</p>	K 0029	<p>K029 1. Corrective action for residents affected: No residents were affected by this alleged negative practice; the door stop on the dining room door was removed by the Maintenance Director.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; the door stop on the dining room door was removed by the Maintenance Director.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated of the requirements of smoke resistant partitions and self-closing doors. All other areas of the facility were inspected with no areas of concern noted.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitor by conducting facility rounds and observing smoke resistant partitions and self-closing doors during monthly preventative maintenance rounds, any</p>	08/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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
	<p>a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/14/16 at 10:58 a.m., the Laundry room contained fuel fired appliances. The corridor door in the Laundry room failed to fully self-close and latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>negative findings will be reported to the Administrator and will be corrected immediately. Monthly preventative maintenance monitoring will be reviewed during the facilities Quality Assurance meeting as a means of continued compliance.</p> <p>K029 2. Corrective action for residents affected: No residents were affected by this alleged negative practice; the corridor door to the laundry room was repaired by the Maintenance Director allowing the self-close door to latch into the frame as required.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; the corridor door to the laundry room was repaired by the Maintenance Director allowing the self-close door to latch into the frame as required.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated of the requirements of smoke resistant partitions and self-closing doors. All other areas of the facility were inspected with no areas of concern noted.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitor by conducting facility rounds and observing smoke</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/14/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
(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 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Monthly</p>	K 0050	<p>resistant partitions and self-closing doors during monthly preventative maintenance rounds, any negative findings will be reported to the Administrator and will be corrected immediately. Monthly preventative maintenance monitoring will be reviewed during the facilities Quality Assurance meeting as a means of continued compliance.</p> <p>K050 Corrective action for residents affected: No residents were affected by this alleged negative practice; new forms were implemented to ensure fire drills will be held at varying times as required.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative</p>	08/13/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/14/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
(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 0051 SS=D Bldg. 01	<p>Fire Drill Record" forms with the Maintenance Director on 07/14/16 at 10:13 a.m., four sequential second shift fire drills took place between 9:25 a.m. and 9:55 a.m. for four of the last four quarters. Then, four sequential second shift fire drills took place between 2:15 p.m. and 3:05 p.m. Then again, three sequential third shift fire drills took place between 5:15 a.m. and 5:30 a.m. for three of the last four quarters. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm</p>		<p>practice; new forms were implemented to ensure fire drills will beheld at varying times as required.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated ofthe requirements of fire drills being held at unexpected times under varyingconditions as required. New forms wereimplemented to ensure fire drills will be held at varying times as required.</p> <p>Corrective action will be monitored by: Completed fire drill forms will be reviewedby the Administrator monthly during the facilities Quality Assurance meeting asa means of continued compliance, any negative findings will be will becorrected immediately.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/14/2016	
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534			
(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			
	<p>boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detector in the Maintenance office was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/14/16 at 11:03 a.m., the Maintenance office had a smoke detector located twenty inches away from an HVAC vent. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>	K 0051	<p>K051</p> <p>Corrective action for residents affected: No residents were affected by this alleged negative practice; the air flow vent in the Maintenance office was covered preventing air flow to the smoke detector.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; the air flow vent in the Maintenance office was covered preventing air flow to the smoke detector.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated of the requirements of smoke detectors not being located where air flow could prevent the operation of the detector. All other areas of the facility were inspected with no areas of concern noted.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitor by conducting</p>	08/13/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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 0056 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 1 hydraulic design information sign. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler System, Section 24.5.1 requires that the installing contractor shall identify a hydraulically designed sprinkler system with a permanently marked weatherproof metal or rigid plastic sign secured with corrosion-resistant wire, chain, or other</p>	K 0056	<p>facility rounds and observing smoke detector placement monthly during preventative maintenance rounds, any negative findings will be reported to the Administrator and will be corrected immediately. Monthly preventative maintenance monitoring will be reviewed during the facilities Quality Assurance meeting as a means of continued compliance.</p> <p>K056 1. Corrective action for residents affected: No residents were affected by this alleged negative practice; the facility is currently working with Elwood Fire Co. on replacing the missing hydraulic design information sign.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; the facility is currently</p>	08/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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
	<p>approved means. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/14/16 at 11:05 a.m., the main riser room did not contain a hydraulic design information sign. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for sprinklers in 1 of 1 Laundry room and 1 of 1 Dish room was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Table 5-6.5.1.2 states that distance between a sprinkler head an obstruction less than 1 foot away cannot be lower than the sprinkler head deflector. This deficient practice could affect staff only.</p>		<p>working with Elwood Fire Co. onreplacing the missing hydraulic design information sign.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated ofthe requirements of the hydraulic design information sign placement. The facility is currently working withElwood Fire Co. on replacing the missing hydraulic design informationsign.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitorby conducting facility rounds and observing placement of the hydraulic designinformation sign, any negative findings will be reported to the Administratorand will be corrected immediately. Monthlypreventative maintenance monitoring will be reviewed during the facilitiesQuality Assurance meeting as a means of continued compliance.</p> <p>K056 2. Corrective action for residents affected: No residents wereaffected by this alleged negative practice; the Maintenance Director replacedand repositioned the lighting in the laundry room and the dish room to ensurethe spray pattern of the sprinkler heads would not be obstructed.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/14/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
(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 0062 SS=F	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/14/16 at 10:52 a.m. then again at 11:08 a.m., the spray pattern for one sprinkler head in the Laundry room was located next to ceiling light. Measurements showed the sprinkler head was 8 inches away from the ceiling light. The ceiling light was measured to be 1 inches lower than the sprinkler head deflector. Then again, the spray pattern for two sprinkler heads in the Dish room was located next to ceiling lights. Measurements showed the sprinkler heads were 10 inches away from the ceiling lights. The ceiling lights was measured to be 1 inches lower than the sprinkler head deflectors. Based on interview at the time of observation, the Maintenance Director acknowledged the abovementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; the Maintenance Director replaced and repositioned the lighting in the laundry room and the dish room to ensure the spray pattern of the sprinkler heads would not be obstructed.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated of the requirements of sprinkler heads not being obstructed. All other areas of the facility were inspected with no areas of concern noted.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitor by conducting facility rounds and observing for sprinkler head obstructions, any negative findings will be reported to the Administrator and will be corrected immediately. Monthly preventative maintenance monitoring will be reviewed during the facilities Quality Assurance meeting as a means of continued compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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
Bldg. 01	<p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. Section 10-2.2, Obstruction Prevention, states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director on 07/14/16 at 10:17 a.m., none of the quarterly sprinkler system inspection and testing records indicated an internal inspection of the sprinkler system pipes had been</p>	K 0062	<p>K062</p> <p>Corrective action for residents affected: No residents were affected by this alleged negative practice; the internal examination of the water-based sprinkler piping fire protection system has been scheduled with Elwood Fire and will be completed on or before the correction date.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; ; the internal examination of the water-based sprinkler piping fire protection system has been scheduled with Elwood Fire and will be completed on or before the correction date.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated of the requirement for routine internal examinations of the facility's water-based sprinkler piping fire protection system to be completed every five years. This inspection has been scheduled with Elwood Fire and will be completed on or before the correction date.</p>	08/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/14/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
(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 0143 SS=D Bldg. 01	<p>conducted. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed the sprinkler system is over five years old.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 2 outlets in the liquid oxygen storage areas where oxygen transferring takes place, was protected. This deficient practice could affect staff only.</p>	K 0143	<p>Corrective action will be monitored by: Maintenance Director or designee will monitor by including this routine service in his preventative maintenance monitoring and will be reviewed during the facilities Quality Assurance meeting as a means of continued compliance.</p> <p>K143 Corrective action for residents affected: No residents were affected by this alleged negative practice; the Maintenance Director placed a permanent cover over the outlet in the liquid oxygen storage area.</p> <p>Other residents' affected and</p>	08/13/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  07/14/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
(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 0147 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/14/16 at 11:19 a.m., the oxygen storage/transfer room contained an outlet that was four inches from the ground and no other protection device installed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for</p>	K 0147	<p>corrective action: No residents were affected by this alleged negative practice; the Maintenance Director placed a permanent cover over the outlet in the liquid oxygen storage area.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated of the outlet height requirements and protecting outlets in liquid oxygen storage areas. This is the only liquid oxygen storage area in the facility.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitor by conducting facility rounds and observing that outlets in liquid oxygen storage areas remain protected during monthly preventative maintenance rounds, any negative findings will be reported to the Administrator and will be corrected immediately. Monthly preventative maintenance monitoring will be reviewed during the facilities Quality Assurance meeting as a means of continued compliance.</p> <p>K147 1. Corrective action for residents affected: No residents were affected by this alleged negative practice; the</p>	08/13/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534
--	---

(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
	<p>fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Director on 07/14/16 at 11:33 a.m., an extension cord was powering a Wi-Fi router in the #1 smoke barrier in the attic. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes in #1 smoke barrier attic observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice</p>		<p>Maintenance Director removed the extension cord from the attic area of the smoke barrier #1 and the Wi-Fi router was hard-wired to meet regulations.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; the Maintenance Director removed the extension cord from the attic area of the smoke barrier #1 and the Wi-Fi router was hard-wired to meet regulations.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated on the prohibited use of extension cords that substitute fixed wiring. All other areas of the facility were inspected with no areas of concern noted.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitor by conducting facility rounds and observing that the use of extension cords is not occurring during monthly preventative maintenance rounds and after contracted services are performed, any negative findings will be reported to the Administrator and will be corrected immediately. Monthly preventative maintenance monitoring will be reviewed during the facilities Quality Assurance meeting as a means of continued compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
(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	
	<p>could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 07/14/16 at 11:37 a.m., there was exposed wiring in a junction box without a cover in the #1 smoke barrier in the attic. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>K147 2.</p> <p>Corrective action for residents affected: No residents were affected by this alleged negative practice; the Maintenance Director covered the electrical junction box located in the attic of smoke barrier #1.</p> <p>Other residents' affected and corrective action: No residents were affected by this alleged negative practice; the Maintenance Director covered the electrical junction box located in the attic of smoke barrier #1.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was reeducated on the requirement that all exposed junction boxes shall be covered to meet regulations. All other areas of the facility were inspected with no areas of concern noted.</p> <p>Corrective action will be monitored by: Maintenance Director or designee will monitor by conducting facility rounds and observing that electrical junction boxes are properly covered during monthly preventative maintenance rounds and after contracted services are performed, any negative findings will be reported to the Administrator and will be corrected immediately. Monthly preventative maintenance monitoring will be reviewed during the facilities Quality Assurance</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155283	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER  WINTERSONG VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1005 S EDGEWOOD DR KNOX, IN 46534		
(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	
			meeting as a means of continued compliance.		