

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 04/30/2013
--	---	--	---

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
K010000	<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: 04/30/13</p> <p>Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</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 was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and areas open to the corridor. Resident rooms are equipped with battery powered smoke detectors.</p>	K010000	Submission of this Plan of correction does not constitute an admission to or an agreement with facts alleged on the survey report 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.	

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 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/30/2013
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>The facility has a capacity of 48 and had a census of 33 at the time of this survey.</p> <p>All areas where residents have customary access and all facility service areas were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/08/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</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 04/30/2013
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	
K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure an opening through 1 of 4 smoke barriers was sealed with a material to provide the 1/2 hour fire resistance of the smoke barrier. 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 for the specific purpose. This deficient practice could affect visitors, staff and 15 or more resident in the 200 hall and center smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/30/13 at 2:40 p.m., two pipe penetrations through the</p>	K010025	<p>K025</p> <p>Corrective action for residents affected: The opening through 1 of 4 smoke barriers was sealed with a material to provide the ½ hour fire resistance of the smoke barrier.</p> <p>Corrective action for other residents having potential to be affected: No residents were affected but all residents have the potential to be affected. The opening through 1 of 4 smoke barriers was sealed with a material to provide the ½ hour fire resistance of the smoke barrier. All other smoke barriers were observed and were found to be in compliance.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was educated on need for ½ hour fire resistance of the smoke barrier. The Maintenance Director will observe smoke barriers quarterly and after any contracted work and</p>	05/20/2013	

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 04/30/2013
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>200 hall smoke barrier wall above the lay in ceiling were incompletely sealed leaving one half to one inch gaps. The maintenance director said at the time of observation, a contractor had removed part of the seal to install wiring and failed to reseal the penetrated smoke barrier.</p> <p>3.1-19(b)</p>		<p>repair penetrations to the smoke barriers.</p> <p>Corrective action will be monitored by: The Maintenance Director will observe smoke barriers quarterly and after any contracted work. Observations will be reviewed in quarterly Q.A. with negative findings corrected immediately. These observations will be ongoing for continued compliance.</p> <p>Date Corrected: 5-20-2013</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 04/30/2013	
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			
K010062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 observation and interview, the facility failed to ensure sprinkler heads providing protection for 3 of 6 exit discharges and the kitchen were maintained. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff, visitors and 20 or more residents.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/30/13 between 12:05 p.m. and 2:50 p.m., the sprinkler heads protecting exit discharges from the 100, 200 and 300 halls were covered with a green material, evidence of corrosion. One sprinkler head in the dish washing area of the kitchen had paint on it. The maintenance director</p>	K010062	<p>K062</p> <p>Corrective action for residents affected: The dry pendant heads were measured and ordered by Elwood Fire Equipment Co. and will be installed upon arrival.</p> <p>Corrective action for other residents having potential to be affected: No residents were affected but all residents have the potential to be affected. The dry pendant heads were measured and ordered by Elwood Fire Equipment Co. and will be installed upon arrival.</p> <p>Measures to ensure practice does not recur: Maintenance Director was educated on the need of sprinkler heads to be in good condition. Maintenance Director will observe sprinkler Heads quarterly and replace as needed.</p> <p>Corrective action will be monitored by: Maintenance Director will observe sprinkler Heads quarterly and replace as needed.</p> <p>Observations will be reviewed in quarterly Q.A. with negative findings corrected immediately. These</p>	05/20/2013			

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 04/30/2013
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	
	acknowledged at the time of observations, the sprinkler heads were not in good condition. 3.1-19(b)		observations will be ongoing for continued compliance. Date Corrected: 5-20-2013		

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 04/30/2013	
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			
K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen supply storage rooms was separated by construction with a one hour fire resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects staff, visitors and 20 or more residents using the dining room access corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/30/13 at 3:00 p.m., four large liquid oxygen containers were stored in the oxygen storage supply room. A 12 by 12 inch cutout exposed plumbing to the interior of the room leaving a shingle sheet of drywall</p>	K010076	<p>K076</p> <p>Corrective action for residents affected: The oxygen storage room walls were repaired to provide a 1 hour fire resistance.</p> <p>Corrective action for other residents having potential to be affected: No residents were affected but all residents have the potential to be affected. The oxygen storage room walls were repaired to provide a 1 hour fire resistance.</p> <p>Measures to ensure practice does not recur: The Maintenance Director was educated on the need of the oxygen storage rooms to provide a 1 hour fire resistance. Maintenance Director will observe oxygen storage area quarterly and repair negative findings immediately.</p> <p>Corrective action will be monitored by: The Maintenance Director will</p>	05/20/2013			

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 04/30/2013
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	
	between the oxygen storage room and adjacent exit corridor. The maintenance director acknowledged at the time of observation, the cut out compromised the integrity of the wall and it did not provide a fire resistant separation of one hour. 3.1-19(b)		observe oxygen storage area quarterly and repair negative findings immediately. Observations will be reviewed in quarterly Q.A. with negative findings corrected immediately. These observations will be ongoing for continued compliance. Date Corrected: 5-20-2013		

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 04/30/2013	
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			
K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</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;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer rooms was separated by construction with a one hour fire resistant rating. This deficient practice affects staff, visitors and 20 or more residents using the dining room access corridor.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 04/30/13 at 3:00 p.m., the liquid oxygen storage and transfer room was identified by a sign and the maintenance director. A 12 by 12 inch cutout exposed plumbing to the interior of the room leaving a shingle sheet of drywall between the oxygen storage room and adjacent exit corridor.</p>	K010143	K143 Corrective action for residents affected: The oxygen storage room/transfer room walls were repaired to provide a 1 hour fire resistance. Corrective action for other residents having potential to be affected: No residents were affected but all residents have the potential to be affected. The oxygen storage room/transfer room walls were repaired to provide a 1 hour fire resistance. Measures to ensure practice does not recur: The Maintenance Director was educated on the need of the oxygen storage room/ transfer room to provide a 1 hour fire resistance. The Maintenance Director will observe oxygen storage/transfer area quarterly and repair negative findings immediately. Corrective action	05/20/2013			

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 04/30/2013
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	
	The maintenance director acknowledged at the time of observation, the cut out compromised the integrity of the wall and it did not provide a fire resistant separation of one hour. 3.1-19(b)		will be monitored by: The Maintenance Director will observe oxygen storage/transfer area quarterly and repair negative findings immediately. Observations will be reviewed in quarterly Q.A. with negative findings corrected immediately. These observations will be ongoing for continued compliance. Date Corrected: 5-20-2013		