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

PRINTED: 08/01/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG 01, 02, 03	(X3) DATE S COMPL	
	155635	B. WING		R	?9/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0112	.5/2024
GRACE VILLAGE HEALTH CARE FA	CILITY		337 GRACE VILLAGE DR		
GRACE VIELAGE HEAETH CARE LA	OILIT I		WINONA LAKE, IN 46590		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	I	(X5) COMPLETION DATE
{E 000} Initial Comments		{E 00	00}		
Preparedness Survey of conducted by the Indian accordance with 42 CFF Survey Date: 07/29/24 Facility Number: 00050 Provider Number: 1556 AIM Number: 10026626 At this PSR survey, Gra Facility was found in con Preparedness Requirem Medicaid Participating F 42 CFR 483.73. The fact and had a census of 50 Quality Review complete [K 000] INITIAL COMMENTS A Post Survey Revisit (I Code Recertification and conducted on 06/12/24 seconducted	21 235 260 26 26 26 26 26 26 26 26 26 26 26 26 26	{K 00	00}		

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.

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG 01, 02, 03	` '	(X3) DATE SURVEY COMPLETED	
		155635	B. WING_			R 07/29/2024
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590	I	0112312024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{K 000}	Fire Protection Association 1AC 16.2 and was Existing Health Care The facility consists of 1), the 1980 addition rehabilitation and the Bldg. 2 consisting of of a two-story building floor assembly from twas determined to be construction. The built and had a fire alarm in the corridors and in corridors. Battery op were installed in all results.	the 2012 edition of National station (NFPA) 101 LSC and surveyed with Chapter 19 Occupancies. If the original building (Bldg. (Bldg. II), and the 2007 rapy addition (bldg. III). In all 5 and is on the first floor guerated by a two-hour he independent living center of Type II (222) Iding was fully sprinklered system with smoke detection in areas open to the erated smoke detectors esident rooms of hall 5. The prof 89 and had a census of	{K 0	00)		
{K 000}	All areas where the raccess were sprinkle services which were detached garage use maintenance equipm portion of the building garage, and a detach parts and lawn equip separate fire pump b Quality Review complimitation Comments A Post Survey Revist Code Recertification conducted on 06/12/2	esidents have customary red. Areas providing facility not sprinklered included a d for storage of ent and parts with the gused as a maintenance led shed used for storage of ment. The facility had a uilding that was sprinklered.	{K 0	00}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	PLE CONSTRUCTION G 01, 02, 03		ATE SURVEY MPLETED		
		155635	B. WING _		, ا	R 07/29/2024		
	ROVIDER OR SUPPLIER	FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{K 000}	Facility was found in Requirements for Pa Medicare/Medicaid, Life Safety from Fire Fire Protection Asso 410 IAC 16.2 and was Existing Health Care The facility consists 1), the 1980 addition rehabilitation and the Bldg. 2 consisting of of a two-story building floor assembly from was determined to be construction. The buand had a fire alarm in the corridors and corridors. Battery of were installed in all refacility has a capacit 50 at the time of this	O(a). O(b). O(c). O({K 00	,				
	access were sprinkle services which were detached garage use maintenance equipn	ered. Areas providing facility not sprinklered included a						

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION 02, 03	(X3) DATE COMP	SURVEY LETED
		155635	B. WING _				R 29/2024
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY			337	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	parts and lawn equipr separate fire pump bu Quality Review comp	ed shed used for storage of ment. The facility had a uilding that was sprinklered.	{K 0	00}			
{K 000}	Code Recertification a conducted on 06/12/2	t (PSR) to the Life Safety and State Licensure Survey 4 was conducted by the of Health in accordance 42	{K 0	JO}			
	Facility was found in a Requirements for Par Medicare/Medicaid, 4 Life Safety from Fire, Fire Protection Assoc 410 IAC 16.2 and was Existing Health Care The facility consists of 1), the 1980 addition rehabilitation and their Bldg. 3 consisting of the Requirements of	501 5635 6260 Grace Village Health Care compliance with ticipation in 2 CFR Subpart 483.90(a), the 2012 edition of National iation (NFPA) 101 LSC and is surveyed with Chapter 19 Occupancies. If the original building (Bldg. (Bldg. II), and the 2007 apy addition (bldg. III). The rehabilitation hall and the					
	therapy gym was dete (111) construction. Th fully sprinklered and h smoke detection in th	ermined to be of Type V is one-story building was nad a fire alarm system with e corridors, resident rooms, the corridors. The facility					

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01, 02, 03		(X3) DATE SURVEY COMPLETED
		155635	B. WING			R
	ROVIDER OR SUPPLIER			STREET ADDRESS, 337 GRACE VILLA WINONA LAKE,		07/29/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)	
{K 000}	has a capacity of 89 at the time of this survey. All areas where the reaccess were sprinkle services which were detached garage use maintenance equipment of the building garage, and a detach parts and lawn equipment.	esidents have customary red. Areas providing facility not sprinklered included a d for storage of ent and parts with the g used as a maintenance red shed used for storage of ment. The facility had a uilding that was sprinklered.	{K 0	00}		