STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING -- B. WING	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE 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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/26/21 Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860 At this Emergency Preparedness survey, Wintersong Village was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 48 certified beds. At the time of the survey, the census was 24. Quality Review completed on 09/01/21	E 0000	Wintersong Village would like to request paper compliance and will forward a all corrective actions and supporting documentation by compliance date of September 25th, 2021.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING -- B. WING	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE KNOX, IN 46534

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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop an emergency	E 0004	**What Corrective Action(s) Will Be Accomplished For Those**	09/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155283	A. BUILDING -- B. WING	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE 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
	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 08/26/21 between 11:20 p.m. to 11:55 p.m. with the Maintenance Director present, documentation for a complete emergency program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with the initial date of acceptance as 01 01/2015 and then it was listed as being revised on 09/01/2017. Based on interview at the time of record review, the Maintenance Director stated that he could not find the update sheet signed by the previous Administrator and would have a new one signed off on and placed in the Emergency Preparedness Plan immediately. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The Emergency Preparedness Plan will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness Plan being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed annually. Any negative findings will be corrected immediately and forwarded to the	

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	155283	A. BUILDING -- B. WING	08/26/2021

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(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
			Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and			

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	155283	A. BUILDING -- B. WING	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			

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	Based on record review and interview, the facility failed to develop and update emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 08/26/21 between 11:20 p.m. to 11:55 p.m. with the Maintenance Director present, documentation for a complete emergency program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with the initial date of acceptance documented as 01/01/2015 and then listed as being revised on 09/01/2017. Based on interview at the time of record review, the Maintenance Director stated that he could not find the update sheet signed by the previous Administrator and would have a new one signed off on and placed in the Emergency Preparedness Plan immediately. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0013	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The Emergency Preparedness Plan will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness Plan being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed annually. Any	09/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to update the emergency preparedness communication plan at least annually so that it complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 08/26/21 between	E 0029	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What**	09/25/2021

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WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE KNOX, IN 46534

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	11:20 p.m. to 11:55 p.m. with the Maintenance Director present, documentation for a complete emergency program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with the initial date of acceptance documented as 01/01/2015 and then listed as being revised on 09/01/2017. Based on interview at the time of record review, the Maintenance Director stated that he could not find the update sheet signed by the previous Administrator and would have a new one signed off on and placed in the Emergency Preparedness Plan immediately. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The Emergency Preparedness Plan will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness Plan being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)			

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	EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least			

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	annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include:	E 0036	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **How Other Residents Having**	09/25/2021

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K 0000	Based on review of the facility's Emergency Preparedness Plan entitled "Emergency Preparedness Program" on 08/26/21 between 11:20 p.m. to 11:55 p.m. with the Maintenance Director present, documentation for a complete emergency program reviewed by the facility within the most recent twelve-month period was not available for review. The emergency plan available has not been reviewed within the past 12 months with the initial date of acceptance documented as 01/01/2015 and then listed as being revised on 09/01/2017. Based on interview at the time of record review, the Maintenance Director stated that he could not find the update sheet signed by the previous Administrator and would have a new one signed off on and placed in the Emergency Preparedness Plan immediately. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. The Emergency Preparedness Plan will be reviewed by the facility. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** The Emergency Preparedness Plan will be reviewed by the facility. The Maintenance Director will be educated over the Emergency Preparedness Plan being reviewed annually. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the Emergency Preparedness Plan monthly ongoing to ensure the plan is reviewed annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	

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Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/26/21 Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860 At this Life Safety Code survey, Wintersong Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 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 building is partially protected by a natural gas-powered 20 kW emergency generator. The facility has a capacity of 48 and had a census of 24 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached wooden storage sheds that were not sprinklered. Quality Review completed on 09/01/21	K 0000	Wintersong Village would like to request paper compliance and will forward a all corrective actions and supporting documentation by compliance date of September 25th, 2021.	

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WINTERSONG VILLAGE	1005 SOUTH EDGEWOOD DRIVE KNOX, IN 46534

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K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 3 of 4 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 10 residents, 2 staff and 1 visitor. Findings include: Based on observations made with the Maintenance Director on 08/26/21 between 12:00 p.m. and 1:55 p.m. during a tour the facility, the following was noted: 1) a 20 inch wide by 26 inch long by	K 0211	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. Facility will ensure all means of egress will be free from obstacles. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Facility will ensure means of egress will be free from obstacles. All obstacles have been removed from hallway. All staff will be in-serviced on keeping	09/25/2021

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	60-inch-high cart was stored in the Victory Court corridor outside resident rooms #302 and #304. This cart was not currently in use and contained bedsheets, pillowcases, blankets, and adult diapers. 2) a cooler made from P.V.C. pipe with a 40-gallon cooler sitting on it was stored in the Autumn Court corridor outside resident rooms #202 and #204. This cart was not currently in use and contained approximately 4 inches of water. (melted ice) 3) a 20 inch wide by 48 inch long by 66-inch-high cart was stored in the Maple Court corridor outside resident rooms #104 and #106. This cart was not currently in use and contained gowns, facemasks, gloves and other assorted P.P.E. There were also 2 small plastic 20-gallon garbage cans, and a covered 18-gallon garbage can. Based on interview with the Maintenance Director at the time of the observation, he acknowledged the items as being stored in the corridor and added that he has found these items in the corridor before and that he has mentioned it to nursing staff, but they still use the area for storage. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		quarters free from obstacles by completion date. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Corrective action for those residents potentially affected will be ongoing weekly rounds for four weeks. Bi-weekly rounds for eight weeks and monthly for monitoring through QAPI.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:			

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	CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.			

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	18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to maintain the means of egress requirements in 1 of 6 entry / exit doors. NFPA 101 Life Safety Code 2012 Edition at 19.2.2.2.1 states Doors complying with 7.2.1 shall be permitted. 7.2.1.4.1 (4) (c) iii states "The force required to operate the door assembly in the direction of door leaf travel is not more than 30 lbf (133 N) to set the door leaf in motion and not more than 15 lbf (67 N) to close the door assembly or open it to the minimum required width. This deficient practice could affect as many as 4 kitchen staff as well as any employee using the service hall entrance / exit. Findings include: Based on observations made with the Maintenance Director on 08/26/21 at 12:02 p.m. during a tour the facility, the service entrance located in the service hall had to be forcibly kicked open by the Maintenance Director. He pushed on the door several times, but it would	K 0222	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. Facility will ensure all means of egress will be free from obstacles. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient**	09/25/2021

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	not budge until it was kicked near the base of the door. A few moments later an employee entered the door stating she was glad we were there as she can never get the door to open as she is too small to pull the door open as it always seems to be rusted closed. Based on an interview at the time of the observation, the Maintenance Director stated that he has worked on this door for years and can not seem to get it to open and close correctly as many years of snow, rust, and neglect have made the door close to inoperable. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**Practice Does Not Recur:** Facility will ensure means of egress will be free from all locks and latches that require a tool or a key to access. All staff will be in-serviced on keeping quarters free from obstacles by completion date. .**How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor weekly. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
K 0353 SS=E 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			

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	automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation, and interview; the facility failed to ensure 2 of 6 sprinkler heads in the kitchen area were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect as many as 4 staff in the kitchen. Findings include: Based on observation with the Maintenance Director during a tour of the facility at 12:00 p.m. to the two sprinklers in the kitchen located nearest the dish washing machine were green, loaded, and need to be replaced. Based on interview at the time of observation, the Maintenance Director acknowledged the	K 0353	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Documentation provided by fire inspection company will be performed by completion date. Staff re-educated on life safety systematic measures to ensure deficient practice is did not reoccur maintenance tractor designee will other monthly and present at monthly QAPI. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the sprinkler monthly ongoing to ensure the plan is reviewed	09/25/2021

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	aforementioned sprinkler heads and stated that he would have his vendor send a quote to have them replaced as soon as he was able to contact them. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		weekly for eight weeks, monthly for four months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
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 observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 smoke barrier walls were constructed to provide at least a one-half hour fire resistance rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a	K 0372	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the	09/25/2021

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	wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect approximately 10 residents and 6 employees. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 08/26/21 at 12:22 p.m., the shower room located near the nurse's station had two 10-inch by 12-inch holes in the ceiling that were open to the attic space above. Based on an interview at the time of the aforementioned observation, the Maintenance Director stated that he started to do a remodel on the bathroom two years ago, but due to the COVID-19 pandemic, he was unable to finish it. The above mentioned penetrations were acknowledged by the Maintenance Director at the time of observations who stated that he was going to be able to finish the project very soon. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		potential to be affected, no other residents were found to be affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** All deficient smoke barriers have been repaired. Pictures attached. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor facility weekly for eight weeks and monthly ongoing for four months to ensure the all smoke barrier walls are in compliance. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.			

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	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 3 of 5 electrical boxes observed were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 10 residents, 4 staff and 1 visitor. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 08/26/21 at 12:23 p.m., three electrical junction boxes without covers and with exposed electrical wiring were noted in the shower room. Based on an interview at the time of the observation, the Maintenance Director stated that he started to do a remodel on the bathroom two years ago, but due to the COVID-19 pandemic, he was unable to finish it. The above-mentioned penetrations were acknowledged by the Maintenance Director at the time of observations who stated that he was going to be able to finish the project very soon. During the exit conference with the facility Maintenance Director at 2:10 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	K 0511	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents have the potential to be affected, no other residents were found to be affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** Facility will replace and/or repair all electrical boxes that were without covers and with exposed wiring by completion date stated below. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor shower room and rest of the facility to ensure compliance of all electrical boxes for eight weeks and monthly ongoing to ensure compliance. Any negative findings will be corrected immediately and forwarded to the Administrator. A	09/25/2021

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			report of progress will be forwarded to the QAPI committee monthly for minimum of 6 months and plan adjusted accordingly.	