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	10/13/2021

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 08/26/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483. Survey Date: 10/13/21 Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860 At this PSR survey, Wintersong Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483. The facility has 48 certified beds. At the time of the survey, the census was 26. Quality Review completed on 10/18/21	E 0000	n/a	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/26/21 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/13/21 Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860	K 0000	n/a	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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	At this PSR 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 26 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 10/18/21			
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: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are			

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	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. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies			

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	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/exit door 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 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	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 or obstruction. *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 all locks and latches that require a tool or a	02/16/2022

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	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 cannot 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 Post Survey Revisit (PSR) on 10/13/21 at 9:40 a.m. the Maintenance Director advised that the door had been ordered but had not come in at the vendor yet due to shipping delays nationwide. This deficiency was cited on 08/26/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		key to access. All staff will be in-serviced on keeping quarters free from obstacles and ensuring door is working in proper manor by completion date. Door has been ordered through the vendor and will be replaced when it comes in from the manufacturer. *How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur: The Maintenance Director/Designee will monitor the door weekly. Document findings and adjust door as needed until door is fully replaced. Door has been ordered through vendor and will be replaced when the door comes in from the manufacturer. 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.	