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	08/10/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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: 08/10/22 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 29. Quality Review on 08/12/22.	E 0000		
E 0037 SS=C Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,			

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training.			

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	(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility	E 0037	Tag # 037 SS = C	09/02/2022

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	failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance and Environmental Services Director on 08/10/22 between 10:15 a.m. and 12:55 p.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Throughout the day the Interim Administrator searched for documentation reflecting staff training on the EPP but was unable to locate the aforementioned documentation. Based on an interview at the time of records review, the Maintenance and Environmental Services Director did not know if staff were trained on the EPP and stated no documentation for staff training could not be found during the survey. This finding was acknowledged by the Maintenance and Environmental Services Director		**EP Training Program** It is the standard of Wintersong Village to ensure all staff are trained on the facilities Emergency Preparedness Program upon hire and at least every two years thereafter. **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 residing in the facility had the potential to be affected by this alleged deficient practice. No residents were 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 staff will be in-serviced on the facilities emergency preparedness program by 9/2/22 by the maintenance Director. A form was added to the new hire packet to ensure new hires are initially in-serviced over the facilities EP Program. A policy and training are being created for the facilities EP plan and it will be added to the list for annual in-services to ensures	

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	at the time of discovery and again at the Exit Conference with the Maintenance and Environmental Services Director and Interim Administrator present.		are trained no less than every two years on the EPP. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** An auditing tool was created to monitor that all new hires are being in-serviced on the facilities Emergency Preparedness Program. The admin/designee will review all new hires orientation weekly for 8 weeks, biweekly for 8 weeks, and monthly for 2 months. Any negative findings will be corrected immediately and forwarded to the administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and plan adjusted accordingly.	
K 0000 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: 08/10/22 Facility Number: 000181 Provider Number: 155283 AIM Number: 100266860 At this Life Safety Code survey, Wintersong Village was found not in compliance with	K 0000		

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	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 29 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 on 08/12/22.			
K 0353 SS=F 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 _____			

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	c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial 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 1 of 1 private fire hydrant was continuously maintained in reliable operating condition. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents in the facility. Findings include: Based on records review and interview with the Maintenance and Environmental Services Director on 08/10/22 between 10:15 a.m. and 12:55 p.m., it was discovered that the facility maintains 1 private fire hydrant. The facilities contractor report of the hydrant inspection dated 07/25/22 indicated the "fire hydrant is seized in the closed position." The Maintenance and Environmental Services Director stated that they were able to open the hydrant, but it took both of them and it was hard. He also stated that the facilities corporate office is aware of the hydrant issue and they are awaiting approval to repair/replace the hydrant. This finding was acknowledged by the Maintenance and Environmental Services Director at the time of discovery and again at the Exit Conference with the Maintenance and Environmental Services Director and Interim Administrator present.	K 0353	Tag # K353 SS = F Sprinkler System – Maintenance & Testing Wintersong Village does ensure that private fire hydrants are continuously maintained in reliable operating conditions. **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 residing in the facility had the potential to be affected by this alleged deficient practice. No residents were 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?** When the hydrant was failed during the recent annual inspection on 7/25/2022 the facilities corporate director of plant	09/02/2022

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	3.1-19(b)		operations began obtaining quotes for replacement. Our contracted service provider IEI will be scheduling a date to replace/repair the hydrant as soon as they can secure the needed parts. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The fire hydrant will continue to be inspected annually and after each operation by our contracted service provider IEI. Any negative findings will be corrected immediately and forwarded to the administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and plan adjusted accordingly.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches			

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	for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 12 residents on the 300 Hall. Findings include: Based on observations and interview during a tour of the facility with the Maintenance and Environmental Services Director on 08/10/22 between 12:55 p.m. and 3:15 p.m., the set of smoke barrier doors on the 300 Hall would not close due to a Hoyer Lift parked up against one of the smoke doors. This condition would leave the door partially open upon activation of the fire alarm. Based on interview during the time of observation, the Maintenance and Environmental Services Director stated the door was part of a smoke barrier, was blocked from closing and he removed the lift from blocking the door.g This finding was acknowledged by the Maintenance and Environmental Services Director at the time of discovery and again at the Exit Conference with the Maintenance and Environmental Services Director and Interim Administrator present. 3.1-19(b)	K 0374	Tag # K374 SS = E Subdivision of Building Spaces – Smoke Barriers Wintersong Village does ensure smoke barrier doors restrict the movement of smoke for at least 20 minutes. **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 residing in the 300 hall of the facility had the potential to be affected by this alleged deficient practice. No residents were 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 staff will be in serviced by 9/2/2022 by the maintenance director and admin on the importance of keeping smoke doors clear and not storing items like lifts, w/c, etc. to obstruct their path. **How the corrective action(s)**	09/02/2022

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? An auditing tool was created to monitor all smoke doors and ensure they are free from obstruction. The Maintenance Director/Designee will monitor all smoke doors 5 times a week for 10 weeks, 2 times a week for 6 weeks, weekly for 4 weeks, and monthly for 2 months. Any negative findings will be corrected immediately and forwarded to the administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and plan adjusted accordingly. **Date of Compliance:** 09/02/2022	
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. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1.	K 0511	Tag # K511 SS = E Utilities – Gas and Electric Wintersong Village does ensure wet locations are provided with	09/02/2022

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	LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without		ground fault circuit interrupter (GFCI) protection against electric shock. **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 residing in the facility had the potential to be affected by this alleged deficient practice. No residents were 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?** The outlet located behind the washer was replaced to a GFCI outlet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The maintenance director did another walk through and inspected all wet locations and ensured all GFCI Outlets were present where required, with no negative findings. An auditing tool	

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	155283	A. BUILDING 01 B. WING	08/10/2022

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	GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 4 staff in the laundry area. Findings include: Based on observations and interview during a tour of the facility with the Maintenance and Environmental Services Director on 08/10/22 between 12:55 p.m. and 3:15 p.m., the washing machine in the laundry area was connected to an electric receptacle which was being used to power the freestanding washing machine, with it's own water supply 1 foot away. The washing machine was not provided with ground fault circuit interruption (GFCI). The Maintenance and Environmental Services Director at the time of observation stated he did not believe the receptacle was on a GFCI circuit. This finding was acknowledged by the Maintenance and Environmental Services Director at the time of discovery and again at the Exit		was created to monitor all wet locations for GFCIs. The maintenance director/designee will monitor all wet locations for needed GFCIs Weekly for 12 weeks and monthly for 3 months.	

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	Conference with the Maintenance and Environmental Services Director and Interim Administrator present. 3.1-19(b)			
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.	K 0761	Tag # K761 SS = E Maintenance, Inspection, & Testing – Doors Wintersong Village does ensure annual inspection and testing of fire door assemblies. **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 residing in the facility had the potential to be affected by this alleged deficient practice. No residents were 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?** The self-closing fire door on the O2 room was added to the weekly fire door inspection list.	09/02/2022

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	(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 8 residents and 2 staff. Findings include: Based on records review and interview with the Maintenance and Environmental Services Director on 08/10/22 between 10:15 a.m. and 12:55 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on interview at the time of records review, the Maintenance and Environmental Services Director stated the annual fire door inspection was not completed within the last year and was previously unaware a fire door inspection was needed on the Transfilling Room door. No documentation was available reflecting a door inspection prior to January 2020 and the beginning of the 1135 COVID waiver.		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** An auditing tool was created to monitor all self-closing fire doors are being inspected weekly. The Administrator/Designee will monitor that all self-closing fire doors are being inspected weekly for 12 weeks and monthly for 3 months. Any negative findings will be corrected immediately and forwarded to the administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and plan adjusted accordingly.	

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	This finding was acknowledged by the Maintenance and Environmental Services Director at the time of discovery and again at the Exit Conference with the Maintenance and Environmental Services Director and Interim Administrator present. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strips in	K 0920	Tag # K920 SS = E Maintenance, Inspection, &	09/02/2022

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	patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym. Findings include: Based on observations and interview during a tour of the facility with the Maintenance and Environmental Services Director on 08/10/22 between 12:55 p.m. and 3:15 p.m., a power strip was in use in the therapy gym where resident care was provided that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance and Environmental Services Director agreed a power strip was in use in a resident care area and did not meet 1363A or 60601-1, stating he was unaware it was a requirement in therapy areas. This finding was acknowledged by the Maintenance and Environmental Services Director at the time of discovery and again at the Exit Conference with the Maintenance and Environmental Services Director and Interim Administrator present. 3.1-19(b)		Testing – Doors Wintersong Village does ensure flexible cord power strips in patient care locations meet the required UL rating of 1363A or 60601-1. **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 residing in the facility had the potential to be affected by this alleged deficient practice. No residents were 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?** The power strip was removed from the therapy gym. All staff will be in-serviced by 9/2/2022 by the maintenance director and admin on the power strip policy. The maintenance director did a walkthrough of the facility to ensure that were no more nonrated power strips were available in the facility. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur, i.e., what quality assurance program will be put into place? An auditing tool was created to monitor that no nonrated power strips are present in the facility. The maintenance director/designee will monitor this 3 times a week for 8 weeks, weekly for 6 weeks, biweekly for 4 weeks and monthly for 2 months. Any negative findings will be corrected immediately and forwarded to the administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum of 6 months and plan adjusted accordingly.	