

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155635	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2024
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NAME OF PROVIDER OR SUPPLIER  GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 06/12/24</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>At this Emergency Preparedness survey, Grace Village Health Care Facility was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 89 and had a census of 48 at the time of this survey.</p> <p>Quality Review completed on 06/21/24</p>	E 0000	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	
E 0025 SS=F Bldg. --	<p>403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6)</p> <p>Arrangement with Other Facilities</p> <p>§403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6).</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Justin Kimbrell	CEO	07/11/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>[(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>*[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients.</p>			

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	<p>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan (EEP) with the Administrator and Maintenance Director on 06/12/24 between 1:30 p.m. and 2:00 p.m., development of written arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was not available for review. Based on an interview during records review, the Administrator stated the facility does have arrangements with other LTC facilities but the documentation of the agreements could not be found.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p>	E 0025	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency E025.</p>	07/06/2024	

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			<p><b>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;</b></p> <p>This deficient practice has the potential to affect all occupants. A mutual aid agreement was signed with Healthwin on 6/28/2024.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>New mutual aid agreements were signed. These mutual aid agreement will be reviewed during the 1st Quarter QA committee meeting and these mutual aid agreements will be resigned during that time.</p> <p><b>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; and</b></p> <p>New mutual aid agreements were signed. These mutual aid agreement will be reviewed during the 1st Quarter QA committee meeting and these mutual aid agreements will be resigned during that time.</p>	

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E 0026 SS=F Bldg. --	<p>403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7)</p> <p>Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7).</p> <p>[(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]</p> <p>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.</p> <p>Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EEP) include the role of the LTC facility under a</p>	E 0026	<b>This plan of correction also represents the facility's allegations of compliance. The</b>	07/06/2024

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	<p>waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b) (8). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Administrator on 06/12/24 at 1:41 p.m., a policy and procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was not available for review. Based on interview at the time of record review the Administrator stated the 1135 waiver policy could not be found.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p>		<p><b>following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency E026.</p> <p><b>how other residents having the potential to be affected by the same deficient</b></p>	

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K 0000  Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana	K 0000	<p><b>practice will be identified and what corrective action(s) will be taken;</b></p> <p>This deficient practice has the potential to affect all residents. A policy and procedure was created for the 1135 waiver and included into the emergency preparedness plan.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>This new policy and procedure will be reviewed at least annually during the annual review of the emergency preparedness plan.</p> <p><b>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; and</b></p> <p>New 1135 waiver policy and procedure was added to the emergency preparedness plan. These new policies and procedures will be reviewed during the 1st Quarter QA committee meeting.</p> <p><b>This plan of correction also represents the facility's</b></p>	

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	<p>Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 06/12/24</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>At this LSC survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101 LSC and 410 IAC 16.2 and was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>The facility consists of the 1970 original building (Bldg. I), the 1980 addition (Bldg. II), and the 2007 rehabilitation and therapy addition (bldg. III).</p> <p>Bldg. I consisting of halls 1, 2, 3, and the main dining room was determined to be Type III (211) construction. Bldg. I was fully sprinklered and had a fire alarm system with smoke detection in the corridors and in areas open to the corridors. Resident rooms 196, 399, and 435 contained hard wire smoke detection and all other resident rooms in Bldg. I contained battery operated smoke detectors. The facility has a capacity of 89 and had a census of 48 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn</p>		<p><b>allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	

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K 0271 SS=E Bldg. 01	<p>equipment. The facility had a separate fire pump building that was sprinklered.</p> <p>Quality Review completed on 06/21/24</p> <p>NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge from the main dining room had walking surface that was free of obstructions. This deficient practice could affect 35 residents using the dining room emergency exit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/12/24 at 12:49 p.m., the exit discharge for the dining room was obstructed with 3 red pylons outside the exit door. Based on interview at the time of observation, the Maintenance Director agreed the exit discharge was obstructed with three 3 red pylons and stated he did not know why the pylons were blocking the exit.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>	K 0271	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged</b></p>	07/06/2024

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			<p><b>deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K271.</p> <p><b>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;</b></p> <p>The deficient practice has the potential to affect 35 residents using the dining room emergency exit. The 3 red pylons outside the exit door have been removed and the exit is now free of obstructions.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Exit door pathways were added to PM checklists. All maintenance personnel were in-serviced on K271 and importance of all exits being free of obstructions.</p>	

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K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or		<b>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; and</b>  The Director of Maintenance or designee will check exit doors monthly for at least 6 months to ensure that no exit is out of compliance by being obstructed. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.	

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	<p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>Based on observation and interview, the facility failed ensure 1 of 1 hood systems with cooking equipment open to the corridor meet the requirements of LSC 19.3.2.5.3 which states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met:</p> <p>LCS TIA 12-2 19.3.2.5.3 states within a smoke compartment, where residential or commercial cooking equipment is used to prepare meals for 30 or fewer persons, one cooking facility shall be permitted to be open to the corridor, provided that all of the following conditions are met:</p> <p>(1) The portion of the health care facility served by the cooking facility is limited to 30 beds and is separated from other portions of the health care facility by a smoke barrier constructed in accordance with 19.3.7.3, 19.3.7.6, and 19.3.7.8.</p> <p>(2) The cooktop or range is equipped with a range hood of a width at least equal to the width of the cooking surface, with grease baffles or other grease-collecting and clean-out capability.</p> <p>(3)* The hood systems have a minimum airflow of 500 cfm (14,000 L/min).</p> <p>(4) The hood systems that are not ducted to the exterior additionally have a charcoal filter to remove smoke and odor.</p> <p>(5) The cooktop or range complies with all of the</p>	K 0324	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s)</b></p>	07/06/2024
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2024
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NAME OF PROVIDER OR SUPPLIER  GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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	<p>following:</p> <p>(a) The cooktop or range is protected with a fire suppression system listed in accordance with UL 300, or is tested and meets all requirements of UL 300A, in accordance with the applicable testing document's scope.</p> <p>(b) A manual release of the extinguishing system is provided in accordance with NFPA 96, Section 10.5.</p> <p>(c) An interlock is provided to turn off all sources of fuel and electrical power to the cooktop or range when the suppression system is activated.</p> <p>(6)* The use of solid fuel for cooking is prohibited.</p> <p>(7)* Deep-fat frying is prohibited</p> <p>(8) Portable fire extinguishers in accordance with NFPA 96 are located in all kitchen areas.</p> <p>(9)* A switch meeting all of the following is provided:</p> <p>(a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range.</p> <p>(b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision.</p> <p>(c) The switch is on a timer, not exceeding a 120-minute capacity that automatically deactivates the cooktop or range, independent of staff action.</p> <p>(10) Procedures for the use, inspection, testing, and maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the manufacturer's instructions and are followed.</p> <p>(11)* Not less than two AC-powered photoelectric smoke alarms with battery backup, interconnected in accordance with 9.6.2.10.3, and equipped with a silence feature are located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range.</p> <p>(12)* The smoke alarms required by 19.3.2.5.3(11) are permitted to be located outside the kitchen</p>		<p><b>will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K324.</p> <p><b>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;</b></p> <p>The deficient practice has to potential to affect 30 residents in the dining room. The oven/griddle have since been discontinued for cooking purposes.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The oven/griddle will not be used for cooking until a UL 300 extinguishing system has been installed.</p> <p><b>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; and</b></p> <p>The results of these audits will be provided to the facility Quality Assurance Performance</p>	

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	<p>area where such placement is necessary for compliance with the 20- ft (7.6-m) minimum distance criterion.</p> <p>(13)* A single system smoke detector is permitted to be installed in lieu of the smoke alarms required in 19.3.2.5.3(11) provided the following criteria are met:</p> <p>(a) The detector is located not closer than 20 ft (6.1 m) and not further than 25 ft (7.6 m) from the cooktop or range.</p> <p>(b) The detector is permitted to initiate a local audible alarm signal only.</p> <p>(c) The detector is not required to initiate a building-wide occupant notification signal.</p> <p>(d) The detector is not required to notify the emergency forces.</p> <p>(e) The local audible signal initiated by the detector is permitted to be silenced and reset by a button on the detector or by a switch installed within 10 ft (3.0 m) of the system smoke detector.</p> <p>(14) System smoke detectors that are required to be installed in corridors or spaces open to the corridor by other sections of this chapter are not used to meet the requirements of 19.3.2.5.3(11) and are located not closer than 25 ft (7.6 m) to the cooktop or range.</p> <p>This deficient practice could affect 30 residents in the dining room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 06/12/24 at 12:50 p.m., the kitchenette in the dining room contained a flat top grill used to prepare food with grease, was open to the corridor, and was not covered by an UL 300 extinguishing system. Based on interview at the time of observation, the Maintenance Director agreed the kitchenette was open to the corridor and was not covered by UL 300 extinguishing</p>		Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.	

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K 0331 SS=E Bldg. 01	<p>system. At 1:00 p.m. the Director of Dietary Services stated butter is used to cook items such as a grilled cheese sandwich (cheese toasty).</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s).</p> <p>Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish on 3 of 3 corridor walls in building one met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. and 10.2.3.4 LSC 101 (2012 edition). This deficient practice could affect 30 residents in building one.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/12/24 between 11:58 a.m. and 1:30 p.m., in building one the lower 1/3rd of the corridor walls was covered with vinyl wall covering. Based on records review at 1:35 p.m., no documentation of the flame spread rating for the</p>	K 0331	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps</b></p>	07/06/2024

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	<p>vinyl wall covering was available for review. Based on an interview at the time of observation and records review, the Maintenance Director stated the flame spread documentation for the vinyl wall covering could not be located.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>are only included because a plan of correction is required by law. The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K331.</p> <p><b>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;</b></p> <p>The deficient practice has to potential to affect 30 residents in building one. The fire rating for the vinyl wall that covers the lower 1/3rd of the corridor wall in building one was found. The rating was found to be class A.</p> <p><b>what measures will be put into place and what systemic changes will be made to</b></p>	

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K 0345 SS=F Bldg. 01	<p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility</p>	K 0345	<p><b>ensure that the deficient practice does not recur;</b></p> <p>The flame spread documentation was indeed found after the exit conference. See supporting documentation.</p> <p><b>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; and</b></p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also</b></p>	07/06/2024

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	<p>failed to ensure 1 of 1 fire alarm systems were maintained in accordance with LSC 9.6.1.3, NFPA 70 National Electrical Code, and NFPA 72 National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 10:22 a.m., the following tests and inspections were past due or missing:</p> <p>a.) The last annual fire alarm inspection was conducted on 05/30/23 (12) days past due.</p> <p>b.) No documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection on 05/30/23.</p> <p>c.) The last smoke detector sensitivity test inspection was conducted on 03/05/22 (3) months past due.</p> <p>Based on an interview at the time of records review, the Maintenance Director stated the aforementioned inspections were not completed on time.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K345.</p>	

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			<p><b>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;</b></p> <p>The deficient practice has the potential to affect all occupants in the facility. The annual fire inspection and sensitivity test were completed by Fire Alarm system company Priority 1 on 6/26/2024.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Annual fire inspection and sensitivity test completed by Fire Alarm system company Priority 1 on 6/26/2024. We have also developed a visual inspection audit form for the next 6 months.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists every 6 months to ensure that semiannual/annual fire inspection was conducted, and upcoming visual inspection will be</p>	

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K 0712 SS=F Bldg. 01	<p>NFPA 101 Fire Drills Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.</p> <p>Findings include:</p>	K 0712	<p>completed, and any non-compliant conditions were corrected. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission</b></p>	07/06/2024

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	<p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 11:12 a.m., no documentation was available to show a second shift fire drill for the third quarter of 2023 was conducted. Based on an interview at the time of record review, the Maintenance Director stated the aforementioned drill was not conducted.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p><b>that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K712.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all staff and residents. We have since completed our quarterly fire drills. We have developed an audit tool</p>	

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K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations		<p>to ensure this does not reoccur. <b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K 712 and the importance of varying the times of quarterly drills. Audit form was established to ensure it does not reoccur.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that fire drill times are conducted properly, and any non-compliant conditions were corrected.</p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p>	

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	<p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>Based on observation, records review, and interview; the facility failed to ensure 2 of 2 smoking areas were provided with metal or noncombustible containers with self-closing cover to dispose of cigarette butts. This deficient practice could affect all residents using the front and back exits.</p> <p>Findings include:</p> <p>Based on records review the facility's smoking</p>	K 0741	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan</b></p>	07/06/2024
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	<p>policy with the Maintenance Director on 06/12/24 at 1:30 p.m. stated the smoking area is in the employees' vehicles in the front and back parking lots and the policy did not address how cigarette butts are disposed or location of the butt can. Based on observation with the Maintenance Director at 1:20 p.m., there was not a required noncombustible container with a self-closing lid in the smoking area. Based on an interview at the time of observations and records review, the Maintenance Director agreed there was not a noncombustible container with a self-closing lid provided to dispose cigarette butts.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K741.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all residents using the front and back exits. Non-combustible containers with</p>	

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K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved		self-closing lids have been added to designated areas and our policy has been rewritten to address how cigarette butts are to be disposed of and where to find them in the designated areas.  <b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b>  Maintenance personnel in serviced on K 741 and the importance of having noncombustible containers with self-closing lids in designated smoking areas. <b>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; and</b> The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.	

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	<p>fire-retardant coating that is listed and labeled for product.</p> <ul style="list-style-type: none"> <li>o Decorations meet NFPA 701.</li> <li>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.</li> <li>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).</li> <li>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.</li> </ul> <p>19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 50 resident room corridor doors in building one was not covered with combustible decorations that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met:</p> <p>(1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied.</p> <p>(2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.</p> <p>(3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source.</p> <p>(4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following:</p> <p>(a) Decorations on non-fire-rated doors do not interfere with the operation or any required</p>	K 0753	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	07/06/2024

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	<p>latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d).</p> <p>(b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7.</p> <p>(c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>(d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>This deficient practice could affect 30 residents in building one.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 06/12/24 at 1:20 p.m., room door 407 had combustible decorations covering more than 45% of the door. Based on an interview at the time of the observation, the Maintenance Director agreed the corridor door was covered with combustible decorations exceeding 30%.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p>		<p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K753.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect the 30 residents in building one. The combustible decorations have since been removed from the 1 door observed.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance and activities personnel in-serviced on K753 and the importance of not covering doors with combustible decorations that exceed 30% of the door.</p> <p><b>how the corrective action(s)</b></p>	
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K 0761 SS=C Bldg. 01	Based on records review and interview the facility failed to ensure annual inspection and testing of 6 of 6 fire door assemblies were completed in accordance with LSC. Section 8.3.3.1 states openings required to have a fire protection meet the requirements of NFPA 80. Section 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:	K 0761	<p><b>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that doors are not covered by combustible decorations or covered greater than 30%. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken</b></p>	07/06/2024

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	<p>(1) No open holes or breaks exist in surfaces of either the door or frame.</p> <p>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.</p> <p>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.</p> <p>(4) No parts are missing or broken.</p> <p>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.</p> <p>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 10:27a.m., the documentation of an annual inspection for the fire door assemblies dated AUG. 2023 was not itemized. The inspection form only noted the fire doors were checked, but the form did not indicate if (11) required items were verified. Based on interview at the time of records review and observation, the Maintenance Director agreed the required inspection items were</p>		<p><b>by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K761.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all residents.</p> <p>Maintenance identified the issue. We completed our monthly fire door inspection however did not have the audit forms itemized with</p>	

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	<p>not listed on the inspection form.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p>the 11 required items. The audit forms was recreated to include the 11 items and the fire doors were reaudited.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K761 and on the new itemized audit forms. Annual inspection will be completed using these new itemized forms.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that annual inspection is completed properly, and any non-compliant conditions were corrected.</p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p>	

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K 0916 SS=F Bldg. 01	<p><b>NFPA 101</b> Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/12/23 at 12:36 p.m., the generator's annunciator panel at the main nurse's station was not working when tested. This condition would not alert staff if there was a generator malfunction. Based on an interview at the time of observation, the Maintenance Director agreed the generator's annunciator panel was not working.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>	K 0916	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	07/06/2024
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			<p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K916.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all residents, staff, and visitors. The generator's annunciator panel at the main nurses' station has since been fixed to alert staff in case of an generator malfunction.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The generator's annunciator panel has been fixed and will be added to the PM checklist monthly for at least 6 months.</p> <p><b>how the corrective</b></p>	

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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		<b>action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</b>  The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that the generators annunciator panel is working to indicate alarm conditions of the emergency power source. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.	

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	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 10 residents by the admin offices in building one.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Director on 06/12/24 at 12:22 p.m., a refrigerator, microwave, and an ice machine (high power draw equipment) were plugged into and supplied power by a power strip in the scheduling office. Based on interview at the time of observation, the Maintenance Director agreed a power strip was supplying power to high power draw equipment.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>	K 0920	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	07/06/2024
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			<p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K920.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect up to 10 residents by the admin offices in building one.</p> <p>The extension cord used in the room observed were removed on 6/12/2024. All resident rooms, offices, activity areas and common areas were inspected to ensure no other incorrectly applied electrical equipment was in use.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>A policy was written to provide guidelines to all employees on</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2024
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K 0000  Bldg. 02	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana	K 0000	<p>permissible and non-permissible use of extension cords, power strips and surge protectors. Maintenance and activities personnel were in-serviced on the policy which was also distributed electronically to other department heads and managers.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that no incorrectly used electronic equipment (extension cords or multi-plug adaptors) are in use and that any non-compliant conditions were corrected.</p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2024
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	<p>Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 06/12/24</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>At this LSC survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101 LSC and 410 IAC 16.2 and was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>The facility consists of the original building (Bldg. 1), the 1980 addition (Bldg. II), and the 2007 rehabilitation and therapy addition (bldg. III).</p> <p>Bldg. 2 consisting of hall 5 and is on the first floor of a two-story building separated by a two-hour floor assembly from the independent living center was determined to be of Type II (222) construction. The building was fully sprinklered and had a fire alarm system with smoke detection in the corridors and in areas open to the corridors. Battery operated smoke detectors were installed in all resident rooms of hall 5. The facility has a capacity of 89 and had a census of 48 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a</p>		<p><b>allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	

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K 0345 SS=F Bldg. 02	<p>detached shed used for storage of parts and lawn equipment. The facility had a separate fire pump building that was sprinklered.</p> <p>Quality Review completed on 06/21/24</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems were maintained in accordance with LSC 9.6.1.3, NFPA 70 National Electrical Code, and NFPA 72 National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 10:22 a.m., the following tests and inspections were past due or missing:</p> <p>a.) The last annual fire alarm inspection was conducted on 05/30/23 (12) days past due. b.) No documentation was provided regarding a</p>	K 0345	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and</b></p>	07/06/2024

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	<p>visual inspection of the fire alarm system six months after the annual fire alarm inspection on 05/30/22.</p> <p>c.) The last smoke detector sensitivity test inspection was conducted on 03/05/22 (3) months past due.</p> <p>Based on an interview at the time of records review, the Maintenance Director stated the aforementioned inspections were not completed on time.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K345.</p> <p><b>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;</b></p> <p>The deficient practice has the potential to affect all occupants in the facility. The annual fire inspection and sensitivity test were completed by Fire Alarm system company Priority 1 on 6/26/2024.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p>	

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K 0353 SS=E Bldg. 02	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		<p>Annual fire inspection and sensitivity test completed by Fire Alarm system company Priority 1 on 6/26/2024.</p> <p>We have also developed a visual inspection audit form for the next 6 months.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists every 6 months to ensure that semiannual/annual fire inspection was conducted, and upcoming visual inspection will be completed, and any non-compliant conditions were corrected. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p>	

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	<p><b>Water-based Fire Protection Systems.</b> Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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</p> <p>Based on record review and interview, the facility failed to maintain 1 of 3 automatic sprinkler systems. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.4.1.2 states the concentration of antifreeze solution shall be limited to the minimum necessary for the anticipated minimum temperature. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect 20 residents, staff, and visitors in building # 2.</p> <p>Findings include:</p> <p>Based on review of the facility's annual sprinkler system inspection report with the Maintenance Director and the Maintenance Coordinator on 03/26/24 at 10:28 a.m., the annual sprinkler report dated 04/04/24 stated the antifreeze system in building two is out of range and tested at -1</p>	K 0353	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	07/06/2024

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	<p>degrees Fahrenheit. The reference section in NFPA Annex Figure A.5.3.4.1 Isothermal Lines - Lowest One-Day Mean Temperature (Fahrenheit) showed the mean lowest temperature for the facility was at -10 Fahrenheit. Based on an interview at the time of record review, the Maintenance Director agreed the antifreeze was tested at -1 degrees, the facility location can get below -1 degrees in the winter, and stated the system has not been corrected.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K353.</p> <p><b>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;</b></p> <p>The deficient practice has the potential to affect 20 residents, staff, and visitors in building #2.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance staff was in serviced on the findings of K353. Shambaugh and Son, L.P. completed the semi-annual inspection dated 4/4/24. Based on the comment left in the report the system passed the tested concentration of antifreeze in</p>	

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K 0511 SS=E Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping		<p>Building #2. Due to a copy and pasted error from the previous year 7/6/23 the report had previous statement. Please see email from Shambaugh for clarification that antifreeze was within range.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that antifreeze is within range and tested at -1 degrees Fahrenheit and that conditions are kept compliant and sprinklers are in good condition.</p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, they will be addressed immediately with the Director of Maintenance. The QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.</p>	

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	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes in the center-hall building two were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities to 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 20 residents in the center-hall of building two.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/12/24 at 12:52 a.m., above the drop ceiling by the beauty shop in building two there was an electrical junction box without a cover and had exposed electrical spliced wiring. Based on an interview at the time of the observations, the Maintenance Director agreed the electrical junction box was not provided with a cover and had exposed spliced wires.</p> <p>This finding was reviewed with the Maintenance and the Administrator during the exit conference.</p> <p>3.1-19(b)</p>	K 0511	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations. <b>what corrective action(s) will be accomplished for those</b></p>	07/06/2024
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			<p><b>residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K511.</p> <p><b>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;</b></p> <p>The deficient practice has the potential to affect 20 residents in the center hall of building two. A cover that is compatible with the junction box and suitable for the conditions in use was installed.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel were in-serviced regarding the code requiring wiring connections in junction boxes to be fully enclosed in the box with a cover plate as well as electrical panels must remain locked. Inspection of junction boxes and locked electrical panels has been added to the monthly PM checklist.</p> <p><b>how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</b></p>	

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K 0712 SS=F Bldg. 02	<p>NFPA 101 Fire Drills Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be</p>	K 0712	<p><b>assurance program will be put into place; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure all junctions boxes are fully enclosed with a cover that is compatible and suitable for the conditions. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's allegations of compliance. The</b></p>	07/06/2024

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	<p>conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 11:12 a.m., no documentation was available to show a second shift fire drill for the third quarter of 2023 was conducted. Based on an interview at the time of record review, the Maintenance Director stated the aforementioned drill was not conducted.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p><b>following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K712.</p> <p><b>how other residents having the potential to be affected by the same deficient</b></p>	

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NAME OF PROVIDER OR SUPPLIER  GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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			<p><b>practice will be identified and what corrective action(s) will be taken;</b></p> <p>This deficient practice has the potential to affect all staff and residents. We have since completed our quarterly fire drills. We have developed an audit tool to ensure this does not reoccur.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K 712 and the importance of varying the times of quarterly drills. Audit form was established to ensure it does not reoccur.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that fire drill times are conducted properly, and any non-compliant conditions were corrected.</p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns</p>	

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K 0741 SS=F Bldg. 02	<p>NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4 Based on observation, records review, and interview; the facility failed to ensure 2 of 2</p>	K 0741	<p>are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's</b></p>	07/06/2024

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	<p>smoking areas were provided with metal or noncombustible containers with self-closing cover to dispose of cigarette butts. This deficient practice could affect all residents using the front and back exits.</p> <p>Findings include:</p> <p>Based on records, review the facility's smoking policy with the Maintenance Director on 06/12/24 at 1:30 p.m. stated the smoking area is in the employees' vehicles in the front and back parking lots and the policy did not address how cigarette butts are disposed or location of the butt can. Based on observation with the Maintenance Director at 1:20 p.m., there was not a required noncombustible container with a self-closing lid in the smoking area. Based on an interview at the time of observations and records review, the Maintenance Director agreed there was not a noncombustible container with a self-closing lid provided to dispose cigarette butts.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K741.</p> <p><b>how other residents having the potential to be</b></p>	

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			<p><b>affected by the same deficient practice will be identified and what corrective action(s) will be taken;</b></p> <p>This deficient practice has the potential to affect all residents using the front and back exits. Non-combustible containers with self-closing lids have been added to designated areas and our policy has been rewritten to address how cigarette butts are to be disposed of and where to find them in the designated areas.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K 741 and the importance of having noncombustible containers with self-closing lids in designated smoking areas.</p> <p><b>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; and</b></p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical</p>	

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K 0753 SS=E Bldg. 02	<p>NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met:</p> <ul style="list-style-type: none"> <li>o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.</li> <li>o Decorations meet NFPA 701.</li> <li>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.</li> <li>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).</li> <li>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.</li> </ul> <p>19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 art room corridor doors in building two was not covered with combustible decorations that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met:</p> <ol style="list-style-type: none"> <li>(1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied.</li> <li>(2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.</li> <li>(3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for</li> </ol>	K 0753	<p>Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a</b></p>	07/06/2024
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	<p>Individual Fuel Packages, using the 20 kW ignition source.</p> <p>(4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following:</p> <p>(a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d).</p> <p>(b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7.</p> <p>(c) Decorations do not exceed 30 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>(d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 10 residents in building two.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 06/12/24 at 1:00 p.m., the art room corridor door had combustible decorations covering more than 70% of the door. Based on an interview at the time of the observation, the Maintenance Director agreed the corridor door was covered with combustible decorations exceeding 30%.</p>		<p><b>plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K753.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect the 30 residents in building one. The combustible decorations have since been removed from the 1 door observed.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient</b></p>	

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K 0761 SS=C Bldg. 02	<p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p> <p>Based on records review and interview the facility failed to ensure annual inspection and testing of 6 of 6 fire door assemblies were completed in accordance with LSC. Section 8.3.3.1 states openings required to have a fire protection meet</p>	K 0761	<p><b>practice does not recur;</b></p> <p>Maintenance and activities personnel in-serviced on K753 and the importance of not covering doors with combustible decorations that exceed 30% of the door.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that doors are not covered by combustible decorations or covered greater than 30%. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of</b></p>	07/06/2024

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	<p>the requirements of NFPA 80. Section 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:</p> <p>(1) No open holes or breaks exist in surfaces of either the door or frame.</p> <p>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.</p> <p>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.</p> <p>(4) No parts are missing or broken.</p> <p>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.</p> <p>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance</p>		<p><b>compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K761.</p> <p><b>how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will</b></p>	

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	<p>Director and the Maintenance Coordinator on 06/12/24 at 10:27a.m., the documentation of an annual inspection for the fire door assemblies dated AUG. 2023 was not itemized. The inspection form only noted the fire doors were checked, but the form did not indicate if (11) required items were verified. Based on interview at the time of records review and observation, the Maintenance Director agreed the required inspection items were not listed on the inspection form.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>be taken;</b></p> <p>This deficient practice has the potential to affect all residents.</p> <p>Maintenance identified the issue. We completed our monthly fire door inspection however did not have the audit forms itemized with the 11 required items. The audit forms was recreated to include the 11 items and the fire doors were reaudited.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K761 and on the new itemized audit forms. Annual inspection will be completed using these new itemized forms.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that annual inspection is completed properly, and any non-compliant conditions were corrected.</p> <p>The results of these audits will be provided to the facility Quality</p>	

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K 0916 SS=F Bldg. 02	<p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/12/23 at 12:36 p.m., the generator's annunciator panel at the main nurse's station was not working when tested. This condition would not alert staff if there was a generator malfunction. Based on an interview at the time of observation, the Maintenance Director agreed the generator's annunciator panel was not working.</p>	K 0916	<p>Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a</b></p>	07/06/2024

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	<p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K916.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all residents, staff, and visitors.</p> <p>The generator's annunciator panel at the main nurses' station has since been fixed to alert staff in case of an generator malfunction.</p> <p><b>what measures will be put into place and what systemic</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2024
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NAME OF PROVIDER OR SUPPLIER  GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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K 0000  Bldg. 03	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR	K 0000	<p><b>changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The generator's annunciator panel has been fixed and will be added to the PM checklist monthly for at least 6 months.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that the generators annunciator panel is working to indicate alarm conditions of the emergency power source.</p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.</p> <p><b>This plan of correction also represents the facility's allegations of compliance. The</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2024
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NAME OF PROVIDER OR SUPPLIER  GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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	<p>483.90(a).</p> <p>Survey Date: 06/12/24</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>At this LSC survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) 101 LSC and 410 IAC 16.2 and was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>The facility consists of the original building (Bldg. 1), the 1980 addition (Bldg. II), and the 2007 rehabilitation and therapy addition (bldg. III).</p> <p>Bldg. 3 consisting of the rehabilitation hall and the therapy gym was determined to be of Type V (111) construction. This one-story building was fully sprinklered and had a fire alarm system with smoke detection in the corridors, resident rooms, and in areas open to the corridors. The facility has a capacity of 89 and had a census of 48 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services which were not sprinklered included a detached garage used for storage of maintenance equipment and parts with the portion of the building used as a maintenance garage, and a detached shed used for storage of parts and lawn equipment. The facility had a separate fire pump building that was sprinklered.</p>		<p><b>following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	

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K 0345 SS=F Bldg. 03	<p>Quality Review completed on 06/21/24</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems were maintained in accordance with LSC 9.6.1.3, NFPA 70 National Electrical Code, and NFPA 72 National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 10:22 a.m., the following tests and inspections were past due or missing:</p> <p>a.) The last annual fire alarm inspection was conducted on 05/30/23 (12) days past due. b.) No documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection on 05/30/23. c.) The last smoke detector sensitivity test</p>	K 0345	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p>	07/06/2024
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	<p>inspection was conducted on 03/05/22 (3) months past due.</p> <p>Based on an interview at the time of records review, the Maintenance Director stated the aforementioned inspections were not completed on time.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were identified by the cited deficiency K345.</p> <p><b>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;</b></p> <p>The deficient practice has the potential to affect all occupants in the facility. The annual fire inspection and sensitivity test were completed by Fire Alarm system company Priority 1 on 6/26/2024.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Annual fire inspection and sensitivity test completed by Fire Alarm system company Priority 1 on 6/26/2024.</p>	

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K 0712 SS=F Bldg. 03	<p>NFPA 101 Fire Drills Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between</p>		<p>We have also developed a visual inspection audit form for the next 6 months.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists every 6 months to ensure that semiannual/annual fire inspection was conducted, and upcoming visual inspection will be completed, and any non-compliant conditions were corrected. The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p>	

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	<p>9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 11:12 a.m., no documentation was available to show a second shift fire drill for the third quarter of 2023 was conducted. Based on an interview at the time of record review, the Maintenance Director stated the aforementioned drill was not conducted.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0712	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations. <b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b></p>	07/06/2024	

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			<p><b>practice;</b></p> <p>No residents were affected by the deficiency cited at K712.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all staff and residents. We have since completed our quarterly fire drills. We have developed an audit tool to ensure this does not reoccur.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K 712 and the importance of varying the times of quarterly drills. Audit form was established to ensure it does not reoccur.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that fire drill times are conducted properly, and any</p>	

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K 0741 SS=F Bldg. 03	<p>NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p>		<p>non-compliant conditions were corrected.</p> <p>The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p>	

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	<p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4</p> <p>Based on observation, records review, and interview; the facility failed to ensure 2 of 2 smoking areas were provided with metal or noncombustible containers with self-closing cover to dispose of cigarette butts. This deficient practice could affect all residents using the front and back exits.</p> <p>Findings include:</p> <p>Based on records, review the facility's smoking policy with the Maintenance Director on 06/12/24 at 1:30 p.m. stated the smoking area is in the employees' vehicles in the front and back parking lots and the policy did not address how cigarette butts are disposed or location of the butt can. Based on observation with the Maintenance Director at 1:20 p.m., there was not a required noncombustible container with a self-closing lid in the smoking area. Based on an interview at the time of observations and records review, the Maintenance Director agreed there was not a noncombustible container with a self-closing lid provided to dispose cigarette butts.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>	K 0741	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations. <b>what corrective action(s) will be accomplished for those residents found to have been</b></p>	07/06/2024
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			<p><b>affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K741.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all residents using the front and back exits. Non-combustible containers with self-closing lids have been added to designated areas and our policy has been rewritten to address how cigarette butts are to be disposed of and where to find them in the designated areas.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K 741 and the importance of having noncombustible containers with self-closing lids in designated smoking areas.</p> <p><b>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; and</b></p> <p>The results of these audits will be</p>	

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K 0761 SS=C Bldg. 03	Based on records review and interview the facility failed to ensure annual inspection and testing of 6 of 6 fire door assemblies were completed in accordance with LSC. Section 8.3.3.1 states openings required to have a fire protection meet the requirements of NFPA 80. Section 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. (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,	K 0761	provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.  <b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law. The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b>	07/06/2024
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	<p>the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Director and the Maintenance Coordinator on 06/12/24 at 10:27a.m., the documentation of an annual inspection for the fire door assemblies dated AUG. 2023 was not itemized. The inspection form only noted the fire doors were checked, but the form did not indicate if (11) required items were verified. Based on interview at the time of records review and observation, the Maintenance Director agreed the required inspection items were not listed on the inspection form.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>		<p>Grace Village requests consideration for the desk review for all citations.</p> <p><b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the deficiency cited at K761.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all residents.</p> <p>Maintenance identified the issue. We completed our monthly fire door inspection however did not have the audit forms itemized with the 11 required items. The audit forms was recreated to include the 11 items and the fire doors were reaudited.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance personnel in serviced on K761 and on the new itemized audit forms. Annual inspection</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155635	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2024
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NAME OF PROVIDER OR SUPPLIER  GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP COD 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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K 0916 SS=F Bldg. 03	<p>NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.</p>		<p>will be completed using these new itemized forms.  <b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that annual inspection is completed properly, and any non-compliant conditions were corrected.  The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.</p>	

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	<p>6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panel was in proper operating condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 06/12/23 at 12:36 p.m., the generator's annunciator panel at the main nurse's station was not working when tested. This condition would not alert staff if there was a generator malfunction. Based on an interview at the time of observation, the Maintenance Director agreed the generator's annunciator panel was not working.</p> <p>This finding was reviewed with the Administrator, the Maintenance Coordinator, and Maintenance Director during the exit conference.</p> <p>3.1-19(b)</p>	K 0916	<p><b>This plan of correction also represents the facility's allegations of compliance. The following combined plan of correction and allegations of compliance is submitted solely because it is required by law and is not an admission to any of the alleged deficiencies or violations. Furthermore, none of the actions taken in this plan of correction are an admission that additional steps should have or could have been taken by the facility to prevent the alleged deficiency. These steps are only included because a plan of correction is required by law.</b></p> <p><b>The facility was in compliance with all licensure and certification requirements at the time of the survey and disputes that any alleged deficiency or violation existed.</b></p> <p>Grace Village requests consideration for the desk review for all citations. <b>what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No specific residents were</p>	07/06/2024	

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			<p>identified by the cited deficiency K916.</p> <p><b>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;</b></p> <p>This deficient practice has the potential to affect all residents, staff, and visitors.</p> <p>The generator's annunciator panel at the main nurses' station has since been fixed to alert staff in case of an generator malfunction.</p> <p><b>what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The generator's annunciator panel has been fixed and will be added to the PM checklist monthly for at least 6 months.</p> <p><b>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; and</b></p> <p>The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that the generators annunciator panel is working to indicate alarm conditions of the emergency power source.</p>	

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

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OMB NO. 0938-039

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			The results of these audits will be provided to the facility Quality Assurance Performance Improvement (QAPI) Committee for review. If at any time concerns are identified, the QAPI committee will consist of at a minimum the CEO, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.		