STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155635	A. BUILDING -- B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/17/23 Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260 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. Quality Review completed on 04/19/23	E 0000	**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.**	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a),			

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

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	§483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency			

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	preparedness plan that must be [evaluated], and updated at least every 2 years. . Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:43 a.m., the annual EEP review form had a date of November of 2021, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the CEO stated the annual EPP review was missed and will start reviewing now. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.	E 0004	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as affected by the deficiency cited at E004. - **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;** On 5/2/23 CEO signed and updated the community Emergency Preparedness plan. The facility will create a annual reminder to complete this going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Human Resources department has made an annual reminder to update and review Emergency Preparedness procedure manual annually with the CEO. The CEO has also set up an annual reminder as well and will review updated EOP in QA	05/12/2023

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			meeting. - **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** The Emergency Preparedness Plan will be included on the agenda of QAPI 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.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2			

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	years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:43 a.m., the annual EEP review form had a date of November of 2021, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the CEO stated the annual EPP Policies and Procedures review was missed and will start reviewing now. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.	E 0013	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as affected by the deficiency cited at E013. - **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;** On 5/2/23 CEO signed and updated the community Emergency Preparedness plan. The facility will create an annual reminder to complete this going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Human Resources department has made an annual	05/12/2023

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			reminder to update and review Emergency Preparedness procedure manual annually with the CEO. The CEO has also set up an annual reminder as well. - **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** The Emergency Preparedness Plan will be included on the agenda of QAPI 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.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC			

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	facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:43 a.m., the annual EEP review form had a date of November of 2021, no other documentation could be found to show the EPP Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the CEO stated the annual EPP Communication Plan review was missed and will start reviewing now. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.	E 0029	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as affected by the deficiency cited at E029. - **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;** On 5/2/23 CEO signed and updated the community Emergency Preparedness plan. The facility will create an annual reminder to complete this going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Human Resources department has made an annual reminder to update and review Emergency Preparedness procedure manual annually with the CEO. The CEO has also set up an annual reminder as well. - **how the corrective action(s) will be monitored to ensure the deficient practice**	05/12/2023

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			will not recur, i.e., what quality assurance program will be put into place; and The Emergency Preparedness Plan will be included on the agenda of QAPI 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.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph			

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	(b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at			

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	paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:43 a.m., the annual EEP review form had a date of November of 2021, no other documentation could be found to show the EPP Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the CEO stated the annual EPP Communication Plan review was missed and will start reviewing now. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.	E 0036	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as affected by the deficiency cited at E036. - **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;** Human Resources Department has added Fire Safety and Emergency preparedness in-service to our Relias system for all employees to complete annually. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Human Resources department has Fire Safety and Emergency Preparedness in-service to automatically be required to all current employees annually. This in-service also	05/12/2023

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			requires a test at the end to show competency. - **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** Human Resources Department will monitor completion of Fire Safety and Emergency Preparedness in-service to all employees throughout the year. These results will be included on the agenda of QAPI 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.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs			

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	at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the			

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

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

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	policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC	E 0037	Grace Village requests consideration for the desk review for all citations.	05/12/2023

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	facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:40 a.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview during records review, the CEO stated the annual EPP training was missed and will start the training on the computer training system. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.		- **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as affected by the deficiency cited at E037. - **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;** Human Resources Department has added Fire Safety and Emergency preparedness in-service to our Relias system for all employees to complete annually. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Human Resources department has Fire Safety and Emergency Preparedness in-service to automatically be required to all current employees annually. This in-service also requires a test at the end to show competency. - **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**	

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			Human Resources Department will monitor completion of Fire Safety and Emergency Preparedness in-service to all employees throughout the year. These results will be included on the agenda of QAPI 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.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based			

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	functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or			

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	(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not			

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	limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:			

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	(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or			

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	(B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency			

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	155635	A. BUILDING -- B. WING	04/17/2023

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	scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 0039	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as affected by the deficiency cited at E039. - **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;** Human Resources Department has added Fire Safety and Emergency preparedness in-service to our Relias system for all employees to complete annually. Tabletop disaster drill is scheduled for May 24th. After completion of this drill, we will schedule our full-scale exercise. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Human Resources department has Fire Safety and	05/24/2023

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	LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:41 a.m., no documentation of a community based annual exercise, an actual natural or man-made emergency, or an annual individual facility-based functional exercise if a community drill is not available was available for review. Also, documentation of an additional annual exercise of choice within the last year was not available for review. Based on an interview during records review, the CEO stated the annual drills were missed and will complete the drills this month. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.		Emergency Preparedness in-service to automatically be required for all current employees annually. This in-service also requires a test at the end to show competency. We will have scheduled our tabletop disaster drill for May 24th and we will establish our annual schedule for our table top and full scale exercises annually. - **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** Human Resources Department will monitor completion of Fire Safety and Emergency Preparedness in-service to all employees throughout the year. We will also review our in-service and tabletop exercise results on the agenda of QAPI 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.	
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	**This plan of correction also represents the facility's allegations of compliance. The following combined plan of**	

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	Survey Date: 04/17/23 Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260 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. The facility consists of the original building (Bldg. 1), the 1980 addition (Bldg. II), and the 2007 rehabilitation and therapy addition (bldg. III). Bldg. 1 consisting of halls 1, 2, 3, and the main dining room was determined to be Type III (211) construction. Bldg. 1 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. 1 contained battery operated smoke detectors. The facility has a capacity of 89 and had a census of 48 at the time of this survey. 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.		**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.**	

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	Quality Review completed on 04/19/23			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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 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. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:22 a.m., the following tests and inspections were past due or missing: a.) The last annual fire alarm inspection was conducted on 03/12/22. b.) No documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection.	K 0345	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K345. - **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;** CEO spoke with Fire Alarm system company Priority 1 on 4/17/23 and discovered they had a glitch on their system so we missed our annual inspection. We have since scheduled our annual inspection for May 22nd. - **what measures will be**	05/22/2023

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	Based on interview at the time of records review, the CEO stated the inspection were not completed due to a contractor computer glitch. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		**put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** We have scheduled annual inspection for 5/22/23. We have also developed a visual inspection audit form for 6 months – 11/22/23. We have these dates set in our PM checklist system. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that 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.	
K 0352 SS=F Bldg. 01	NFPA 101 Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for			

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	integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility failed to maintain monitoring of 1 of 1 sprinkler system fire pumps in accordance with LSC 9.7.2.1. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:01 a.m., the last four sprinkler inspections stated when the tamper switches on the fire pump's two control valves were tested the tamper switches failed because the tamper switches did not show up on the fire control panel when tested. Based on interview at the time records review, the CEO and the	K 0352	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K352. - **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;** CEO spoke with sprinkler system company Shambaugh & Son regarding tamper switch failures that were on our recent report. They stated that the issues on their report was an error on their end and they revised their report to show no errors. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Shambaugh & Son stated they will inform us in the future if there are any failed testing for us to complete immediate follow up.	05/12/2023

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	Maintenance Director agreed the sprinkler reports stated the tamper switches on the fire pump's two control valves failed inspection. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		We will continue with our scheduled sprinkler inspections. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that quarterly sprinkler inspection was conducted 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.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 fire pumps system in accordance with NFPA 25. 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, 8.3.1.1 states diesel engine-driven fire pumps shall be operated weekly. Table 8.1.1.2 states fire pumps systems shall be visually inspected weekly in accordance with 8.2.2. This deficient practice affects all occupants. Findings include: Based on record review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:00 a.m., the facility did not conduct a weekly operational test and a visual inspection of the diesel engine-driven fire pump. Also, the annual fire pump inspection conducted on 04/12/23 stated the operational run test was not conducted per Maintenance Director request. Based on an interview at the time of record review, the CEO stated the weekly operational test and visual inspection were stopped in October of 2021 due to the condition of the pump. The facility original plan during previous survey in January of 2022 was the facility would switch to a municipal water supply and was granted a temporary waiver for one year. The facility was informed in October of 2022 the municipal water installation was delayed and	K 0353	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K353. - **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;** Grace Village previously submitted a temporary waiver with K353 for a fire pump replacement that ends on 10/31/23. A fire pump was ordered on 1/6/23 however lead time for delivery is estimated for September 2023. Facility continues to do weekly inspections of the fire pump in accordance with life safety code. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Environmental services staff were in serviced on the finding of K 353	10/31/2023

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	could not guarantee adequate water pressure once the facility was connected to the water supply. Therefore, the facility purchased a new fire pump, but the pump will not be installed until November of 2023. The Maintenance Director stated the pump does work but can overheat. Therefore, the weekly run is not conducted and there was a short annual operational run test for about 15 minutes, but it was shut off early due to overheating. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		and we will be working with Peerless on the transition of our new fire pump once the material arrives. - **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** The Director of Maintenance or designee will review status of replacement. These results 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, Director of Nursing, Medical Director, or designee attending at least quarterly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 receptacles within 6 feet from a sink were provided with ground fault circuit interrupter (GFCI) protection against electric	K 0511	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s)**	05/12/2023

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	shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could staff that use the medication room. Findings include: Based on observation the Maintenance Director on 04/17/23 at 12:35 p.m., in the main nurse's station medication room there was an electrical outlet within two and a half feet from a sink that was not GFCI protected. Based on interview at the time of observation, the Maintenance agreed the electric receptacle was next to a sink and was		**will be accomplished for those residents found to have been affected by the deficient practice;** No specific residents were identified by the cited deficiency. - **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;** Maintenance personnel replaced electrical outlet near sink with GFCI outlet. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel were in-serviced on code requiring outlets in wet locations require GFCI protection. Inspection of other wet locations have GFCI protection has been added to the monthly PM checklist. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that GFCI protection in all wet locations have been documented and that any non-compliant conditions were	

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	not GFCI protected. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		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, Administrator, Director of Nursing, Medical Director, or designee attending at least quarterly.	
K 0521 SS=C Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure 10 of 10 fire dampers were inspected and documented in accordance with NFPA 80. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents.	K 0521	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K521. - **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;** Maintenance personnel exercised and inspected fusible link dampers throughout the campus. - **what measures will be**	05/12/2023

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	Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:04 a.m., the Fire Damper Inspection dated 10/14/22 indicated the dampers were visually inspected but did not show if the fusible link was removed for testing and ensured full closure and locking-in-place for the dampers. Based on interview at the time of records review, the Maintenance Director stated he did the inspections and did not test the operation of the dampers. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		**put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Exercising dampers have been added to PM checklist and will be performed according the code. - **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** The Director of Maintenance or designee will review PM checklists every 4 years to ensure that damper inspections are conducted, 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.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills 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			

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	routine. Where drills are conducted between 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 quarterly fire drills at unexpected times under varying conditions on all shifts for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:31 a.m., the following shifts did not have fire drills at unexpected times: a. All first shift (6:00 a.m. to 2:00 p.m.) fire drills took place between 8:00 a.m. and 9:00 a.m. b. All second shift (2:00 p.m. to 10:00 p.m.) fire drills took place between 4:00 p.m. and 5: 00 p.m. c. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place between 3:00 a.m. and 4:00 a.m. Based on interview at the time of record review, the Maintenance Director agreed fire drills for all three shifts were not held at unexpected times. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K712. - **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;** Maintenance identified the issue. We completed our quarterly fire drills, however the times during each shift were similar. We have developed a audit tool to ensure this does not continue. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** 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 occur again. - **how the corrective action(s) will be monitored to ensure the deficient practice**	05/12/2023

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			will not recur, i.e., what quality assurance program will be put into place; and 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. 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.	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 8 of 8 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other	K 0761	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K761. - **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;**	05/23/2023

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	Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include:		Maintenance identified the issue. We completed our monthly fire door inspection however did not have a maintenance personnel that had NFPA trained for our annual inspection. We now have a maintenance employee certified through NFPA and will conduct our annual inspections going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel in serviced on K 761 and also NFPA training completed. Annual inspection will be completed by NFPA certified personnel. - **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** The Director of Maintenance or designee will review PM checklists annual inspections to ensure that inspection is completed properly by NFPA trained individuals, 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	

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	Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:53 a.m., no documentation of an annual inspection for the eight fire door assemblies was available for review. Based on observation with the Maintenance Director between 12:00 p.m. and 1:40 p.m., there were eight one-and-a-half-hour cross corridor fire door assembly in the facility. There were three separation fire doors and five horizontal exits. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspections were not completed within the last year. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		Nursing, Medical Director, or designee attending at least quarterly.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this			

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	manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review, and interview, the facility failed to ensure non-hospital grade electrical receptacles at 52 of 52 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:20 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on observations with	K 0914	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K914. - **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;** Maintenance developed an annual audit form and began inspecting all rooms outlets. This annual inspection will be conducted going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel in serviced on K 914. The annual inspection audit form was established and completed by maintenance personnel.	05/12/2023

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	the Maintenance Director between 12:00 p.m. and 2:00 p.m., the facility's 52 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on interview at the time of the observation and records review, the Maintenance Director stated testing was started by the Maintenance Assistant but was not completed. The Maintenance Assistant stated he started the testing but has not finished and did not record the tests that were completed. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(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** The Director of Maintenance or designee will review annual inspection audit form to ensure that the 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.	
K 0000 Bldg. 02	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/17/23 Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260 At this LSC survey, Grace Village Health Care Facility was found not in compliance with Requirements for Participation in	K 0000	**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**	

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	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. The facility consists of the original building (Bldg. 1), the 1980 addition (Bldg. II), and the 2007 rehabilitation and therapy addition (bldg. III). 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. 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. Quality Review completed on 04/19/23		**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.**	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an			

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	automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of 2 storage rooms on Hall five with large amounts of combustible storage and greater than 50 square feet were protected as a hazardous area. This deficient practice could affect 10 residents on Hall five. Findings include: Based on observation with Maintenance Director on 04/17/23 at 1:08 p.m., the old Social Services	K 0321	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No specific residents were identified by the cited deficiency. - **how other residents**	05/12/2023

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	and MDS Coordinator offices on Hall five were used for storage, contained over 20 boxes of supplies, and were greater than 50 square feet making the rooms hazardous areas. The rooms were not protected as hazardous areas because the corridor doors to the rooms were not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the rooms contained large amount of combustible storage, were larger than 50 square feet, and the corridor doors to the rooms were not self-closing. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		**having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** 4/19/23 Maintenance personnel installed closers on two storage room on Hall 5. Hall 5 is closed from residents. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel were in-serviced on code protection of hazardous areas - enclosure. Inspection of other storage rooms was completed on 4/19/23 with no findings. Monthly PM checklist has been updated. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that protection of hazardous areas - enclosure has been reviewed and documented and that 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	

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			are identified, the QAPI committee will consist of at a minimum the CEO, Director of Nursing, Medical Director, or designee attending at least quarterly.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 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 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. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:22 a.m., the following tests and inspections were past due or missing: a.) The last annual fire alarm inspection was conducted on 03/12/22.	K 0345	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K345. - **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;** CEO spoke with Fire Alarm system company Priority 1 on 4/17/23 and discovered they had a glitch on their system so we missed our annual inspection.	05/22/2023

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	b.) No documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection. Based on interview at the time of records review, the CEO stated the inspection were not completed due to a contractor computer glitch. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		We have since scheduled our annual inspection for May 22nd. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** We have scheduled annual inspection for 5/22/23. We have also developed a visual inspection audit form for 6 months – 11/22/23. We have these dates set in our PM checklist system. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that 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.	
K 0352 SS=F	NFPA 101 Sprinkler System - Supervisory Signals			

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Bldg. 02	Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility failed to maintain monitoring of 1 of 1 sprinkler system fire pumps in accordance with LSC 9.7.2.1. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:01 a.m., the last four sprinkler inspections stated when the tamper switches on the fire pump's two control valves were tested the tamper switches failed because	K 0352	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K352. - **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;** CEO spoke with sprinkler system company Shambaugh & Son regarding tamper switch failures that were on our recent report. They stated that the issues on their report was an error on their end and they revised their report to show no errors. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Shambaugh & Son stated they will	05/12/2023

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	the tamper switches did not show up on the fire control panel when tested. Based on interview at the time records review, the CEO and the Maintenance Director agreed the sprinkler reports stated the tamper switches on the fire pump's two control valves failed inspection. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		inform us in the future if there are any failed testing for us to complete immediate follow up. We will continue with our scheduled sprinkler inspections. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that quarterly sprinkler inspection was conducted 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.	
K 0353 SS=F 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 Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 #1). Based on record review and interview, the facility failed to maintain 1 of 1 fire pumps system in accordance with NFPA 25. 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, 8.3.1.1 states diesel engine-driven fire pumps shall be operated weekly. Table 8.1.1.2 states fire pumps systems shall be visually inspected weekly in accordance with 8.2.2. This deficient practice affects all occupants. Findings include: Based on record review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:00 a.m., the facility did not conduct a weekly operational test and a visual inspection of the diesel engine-driven fire pump. Also, the annual fire pump inspection conducted on 04/12/23 stated the operational run test was not conducted per Maintenance Director request. Based on an interview at the time of record review, the CEO stated the weekly operational test and visual inspection were stopped in October of 2021 due to the condition of the pump. The facility original plan during previous survey in January of 2022 was the facility would switch to a municipal water supply	K 0353	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K353. - **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;** Grace Village previously submitted a temporary waiver with K353 for a fire pump replacement that ends on 10/31/23. A fire pump was ordered on 1/6/23 however lead time for delivery is estimated for September 2023. Facility continues to do weekly inspections of the fire pump in accordance with life safety code. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient**	10/31/2023

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	and was granted a temporary waiver for one year. The facility was informed in October of 2022 the municipal water installation was delayed and could not guarantee adequate water pressure once the facility was connected to the water supply. Therefore, the facility purchased a new fire pump, but the pump will not be installed until November of 2023. The Maintenance Director stated the pump does work but can overheat. Therefore, the weekly run is not conducted and there was a short annual operational run test for about 15 minutes, but it was shut off early due to overheating. #2). Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchen storage rooms on Hall five. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 10 residents on Hall five. Findings include: Based on observation with the Maintenance Director on 04/17/23 at 1:14 p.m., in the kitchen storage room on Hall five there were two missing ceiling tiles. This condition could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of observation, the Maintenance Director agreed there two missing ceiling tiles. The findings were reviewed with the CEO, Maintenance Director, and Maintenance		**practice does not recur;** Environmental services staff were in serviced on the finding of K 353 and we will be working with Peerless on the transition of our new fire pump once the material arrives. - **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** The Director of Maintenance or designee will review status of replacement. These results 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, Director of Nursing, Medical Director, or designee attending at least quarterly.	

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	Coordinator during the exit conference. 3.1-19(b)			
K 0521 SS=C Bldg. 02	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure 10 of 10 fire dampers were inspected and documented in accordance with NFPA 80. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:04 a.m., the Fire Damper Inspection dated 10/14/22 indicated the dampers were visually inspected but did not show if the fusible link was removed for testing and	K 0521	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K521. - **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;** Maintenance personnel exercised and inspected fusible link dampers throughout the campus. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Exercising dampers have been added to PM checklist and will be performed according the code. - **how the corrective**	05/12/2023

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	ensured full closure and locking-in-place for the dampers. Based on interview at the time of records review, the Maintenance Director stated he did the inspections and did not test the operation of the dampers. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(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** The Director of Maintenance or designee will review PM checklists every 4 years to ensure that damper inspections are conducted, 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.	
K 0712 SS=C Bldg. 02	NFPA 101 Fire Drills Fire Drills 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. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on all shifts for 4	K 0712	Grace Village requests consideration for the desk review for all citations.	05/12/2023

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	of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:31 a.m., the following shifts did not have fire drills at unexpected times: a. All first shift (6:00 a.m. to 2:00 p.m.) fire drills took place between 8:00 a.m. and 9:00 a.m. b. All second shift (2:00 p.m. to 10:00 p.m.) fire drills took place between 4:00 p.m. and 5: 00 p.m. c. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place between 3:00 a.m. and 4:00 a.m. Based on interview at the time of record review, the Maintenance Director agreed fire drills for all three shifts were not held at unexpected times. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b) 3.1-51(c)		- **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K712. - **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;** Maintenance identified the issue. We completed our quarterly fire drills, however the times during each shift were similar. We have developed a audit tool to ensure this does not continue. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** 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 occur again. - **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** 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	

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			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.	
K 0761 SS=F Bldg. 02	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 8 of 8 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door	K 0761	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K761. - **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;** Maintenance identified the issue. We completed our monthly fire door inspection however did not have a maintenance personnel that had NFPA trained for our annual inspection. We now have a maintenance employee certified through NFPA and will conduct	05/23/2023

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	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, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:53 a.m., no documentation of an annual inspection for the eight fire door assemblies was available for review. Based on observation with the Maintenance Director between 12:00 p.m. and 1:40 p.m., there were eight one-and-a-half-hour cross		our annual inspections going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel in serviced on K 761 and also NFPA training completed. Annual inspection will be completed by NFPA certified personnel. - **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** The Director of Maintenance or designee will review PM checklists annual inspections to ensure that inspection is completed properly by NFPA trained individuals, 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.	

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	corridor fire door assembly in the facility. There were three separation fire doors and five horizontal exits. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspections were not completed within the last year. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 02	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.			

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GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

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	6.3.4 (NFPA 99) Based on observation, record review, and interview, the facility failed to ensure non-hospital grade electrical receptacles at 52 of 52 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:20 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on observations with the Maintenance Director between 12:00 p.m. and 2:00 p.m., the facility's 52 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on interview at the time of the observation and records review, the Maintenance Director stated testing was started by the Maintenance Assistant but was not completed. The Maintenance Assistant stated he	K 0914	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K914. - **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;** Maintenance developed an annual audit form and began inspecting all rooms outlets. This annual inspection will be conducted going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel in serviced on K 914. The annual inspection audit form was established and completed by maintenance personnel. - **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** The Director of Maintenance or designee will review annual	05/12/2023

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	started the testing but has not finished and did not record the tests that were completed. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		inspection audit form to ensure that the 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.	
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 483.90(a). Survey Date: 04/17/23 Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260 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. The facility consists of the original building (Bldg. 1), the 1980 addition (Bldg. II), and the 2007	K 0000	**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**	

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	rehabilitation and therapy addition (bldg. III). 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. 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. Quality Review completed on 04/19/23		**the time of the survey and disputes that any alleged deficiency or violation existed.**	
K 0251 SS=E Bldg. 03	NFPA 101 Dead-End Corridors and Common Path of Travel Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 dead-end corridors did not exceed 30 feet. This deficient practice affects 12 residents in the Rehabilitation Hall.	K 0251	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those**	05/12/2023

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	Findings include: Based on observation with the Maintenance Director on 04/17/23 at 12:43 p.m., the Rehabilitation corridor to the courtyard measured 45 feet in length and led to a door to the outside courtyard with a "NO EXIT" sign posted on the door making this a dead-end corridor. Based on interview at the time of observation, the Maintenance Director agreed to the measurement of the corridor and stated the door had posted "NO EXIT" sign because the courtyard was enclosed and did not lead to a common way. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K251. - **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;** After reviewing the code it was determined that the non-exit sign can be adjusted to an exit sign and it will not be a dead end corridor. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Exit sign was installed in hallway on 5/12/23. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that exit signs are working properly and that 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	

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			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.	
K 0293 SS=E Bldg. 03	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 exit signs in the rehabilitation hall were pointed in the correct direction. This deficient practice could affect 12 residents on the rehabilitation hall. Findings include: Based on observation with the Maintenance Director on 04/17/23 at 12:17 p.m., the exit sign from the rear of the rehabilitation hall was sideways and not pointing to the direction of travel to the exit door. Based on an interview at the time of observation, the Maintenance Director agreed the exit sign was not pointed in the correct direction to the exit. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.	K 0293	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No specific residents were identified by the cited deficiency K293. - **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;** Maintenance personnel replaced direction of exit sign on 4/20/23. - **what measures will be put into place and what**	05/12/2023

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	3.1-19(b)		**systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel were in-serviced on code regarding exit signs and also inspected all other exit signs to ensure they were all facing the correct direction and there were no other findings. Checking exit signs is assigned on the monthly PM checklist. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that all exit signs are functional and that 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.	
K 0345 SS=F Bldg. 03	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance			

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	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 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. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:22 a.m., the following tests and inspections were past due or missing: a.) The last annual fire alarm inspection was conducted on 03/12/22. b.) No documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection. Based on interview at the time of records review, the CEO stated the inspection were not completed due to a contractor computer glitch. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.	K 0345	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K345. - **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;** CEO spoke with Fire Alarm system company Priority 1 on 4/17/23 and discovered they had a glitch on their system so we missed our annual inspection. We have since scheduled our annual inspection for May 22nd. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** We have scheduled annual inspection for 5/22/23. We have also developed a visual inspection audit form for 6 months –	05/22/2023

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	3.1-19(b)		11/22/23. We have these dates set in our PM checklist system. - **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** The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that 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.	
K 0352 SS=F Bldg. 03	NFPA 101 Sprinkler System - Supervisory Signals Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 Based on observation and interview, the facility	K 0352	Grace Village requests	05/12/2023

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	failed to maintain monitoring of 1 of 1 sprinkler system fire pumps in accordance with LSC 9.7.2.1. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:01 a.m., the last four sprinkler inspections stated when the tamper switches on the fire pump's two control valves were tested the tamper switches failed because the tamper switches did not show up on the fire control panel when tested. Based on interview at the time records review, the CEO and the Maintenance Director agreed the sprinkler reports stated the tamper switches on the fire pump's two control valves failed inspection. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference.		consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K352. - **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;** CEO spoke with sprinkler system company Shambaugh & Son regarding tamper switch failures that were on our recent report. They stated that the issues on their report was an error on their end and they revised their report to show no errors. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Shambaugh & Son stated they will inform us in the future if there are any failed testing for us to complete immediate follow up. We will continue with our scheduled sprinkler inspections. - **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**	

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	3.1-19(b)		The Director of Maintenance or designee will review PM checklists monthly for at least 6 months to ensure that quarterly sprinkler inspection was conducted 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.	
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility	K 0353	Grace Village requests	10/31/2023

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	failed to maintain 1 of 1 fire pumps system in accordance with NFPA 25. 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, 8.3.1.1 states diesel engine-driven fire pumps shall be operated weekly. Table 8.1.1.2 states fire pumps systems shall be visually inspected weekly in accordance with 8.2.2. This deficient practice affects all occupants. Findings include: Based on record review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:00 a.m., the facility did not conduct a weekly operational test and a visual inspection of the diesel engine-driven fire pump. Also, the annual fire pump inspection conducted on 04/12/23 stated the operational run test was not conducted per Maintenance Director request. Based on an interview at the time of record review, the CEO stated the weekly operational test and visual inspection were stopped in October of 2021 due to the condition of the pump. The facility original plan during previous survey in January of 2022 was the facility would switch to a municipal water supply and was granted a temporary waiver for one year. The facility was informed in October of 2022 the municipal water installation was delayed and could not guarantee adequate water pressure once the facility was connected to the water supply. Therefore, the facility purchased a new fire pump, but the pump will not be installed until November of 2023. The Maintenance Director stated the pump does work but can overheat. Therefore, the weekly run is not conducted and there was a short annual operational run test for		consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K353. - **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;** Grace Village previously submitted a temporary waiver with K353 for a fire pump replacement that ends on 10/31/23. A fire pump was ordered on 1/6/23 however lead time for delivery is estimated for September 2023. Facility continues to do weekly inspections of the fire pump in accordance with life safety code. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Environmental services staff were in serviced on the finding of K 353 and we will be working with Peerless on the transition of our new fire pump once the material arrives. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	about 15 minutes, but it was shut off early due to overheating. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		**assurance program will be put into place; and** The Director of Maintenance or designee will review status of replacement. These results 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, Director of Nursing, Medical Director, or designee attending at least quarterly.	
K 0521 SS=C Bldg. 03	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review and interview, the facility failed to ensure 10 of 10 fire dampers were inspected and documented in accordance with NFPA 80. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of	K 0521	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K521. - **how other residents having the potential to be affected by the same deficient practice will be identified and**	05/12/2023

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GRACE VILLAGE HEALTH CARE FACILITY	337 GRACE VILLAGE DR WINONA LAKE, IN 46590

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	the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:04 a.m., the Fire Damper Inspection dated 10/14/22 indicated the dampers were visually inspected but did not show if the fusible link was removed for testing and ensured full closure and locking-in-place for the dampers. Based on interview at the time of records review, the Maintenance Director stated he did the inspections and did not test the operation of the dampers. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		**what corrective action(s) will be taken;** Maintenance personnel exercised and inspected fusible link dampers throughout the campus. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Exercising dampers have been added to PM checklist and will be performed according the code. - **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** The Director of Maintenance or designee will review PM checklists every 4 years to ensure that damper inspections are conducted, 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.	
K 0712 SS=C Bldg. 03	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire			

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	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. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on all shifts for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 10:31 a.m., the following shifts did not have fire drills at unexpected times: a. All first shift (6:00 a.m. to 2:00 p.m.) fire drills took place between 8:00 a.m. and 9:00 a.m. b. All second shift (2:00 p.m. to 10:00 p.m.) fire drills took place between 4:00 p.m. and 5: 00 p.m. c. All third shift (10:00 p.m. to 6:00 a.m.) fire drills took place between 3:00 a.m. and 4:00 a.m. Based on interview at the time of record review, the Maintenance Director agreed fire drills for all three shifts were not held at unexpected times. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K712. - **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;** Maintenance identified the issue. We completed our quarterly fire drills, however the times during each shift were similar. We have developed a audit tool to ensure this does not continue. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel in serviced on K 712 and the importance of	05/12/2023

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			varying the times of quarterly drills. Audit form was established to ensure it does not occur again. - **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** 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. 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.	
K 0761 SS=F Bldg. 03	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 8 of 8 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table	K 0761	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K761.	05/23/2023

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	8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label.		- **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;** Maintenance identified the issue. We completed our monthly fire door inspection however did not have a maintenance personnel that had NFPA trained for our annual inspection. We now have a maintenance employee certified through NFPA and will conduct our annual inspections going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance personnel in serviced on K 761 and also NFPA training completed. Annual inspection will be completed by NFPA certified personnel. - **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** The Director of Maintenance or designee will review PM checklists annual inspections to ensure that inspection is completed properly by NFPA trained individuals, and any non-compliant conditions were corrected. The results of these audits will be provided to the	

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	(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:53 a.m., no documentation of an annual inspection for the eight fire door assemblies was available for review. Based on observation with the Maintenance Director between 12:00 p.m. and 1:40 p.m., there were eight one-and-a-half-hour cross corridor fire door assembly in the facility. There were three separation fire doors and five horizontal exits. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspections were not completed within the last year. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		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.	
K 0914 SS=F Bldg. 03	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not			

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	exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review, and interview, the facility failed to ensure non-hospital grade electrical receptacles at 52 of 52 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include:	K 0914	Grace Village requests consideration for the desk review for all citations. - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the deficiency cited at K914. - **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;** Maintenance developed an annual audit form and began inspecting all rooms outlets. This annual inspection will be conducted going forward. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient**	05/12/2023

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	Based on records review with the CEO, Maintenance Director, and the Maintenance Coordinator on 04/17/23 at 11:20 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on observations with the Maintenance Director between 12:00 p.m. and 2:00 p.m., the facility's 52 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on interview at the time of the observation and records review, the Maintenance Director stated testing was started by the Maintenance Assistant but was not completed. The Maintenance Assistant stated he started the testing but has not finished and did not record the tests that were completed. This finding was reviewed with the CEO, Maintenance Director, and Maintenance Coordinator during the exit conference. 3.1-19(b)		**practice does not recur;** Maintenance personnel in serviced on K 914. The annual inspection audit form was established and completed by maintenance personnel. - **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** The Director of Maintenance or designee will review annual inspection audit form to ensure that the 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.	