STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. BUILDING 01 - ST. JOSEPH VILLA 0102 B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH VILLA	451 EAST BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Reviewed by Erik Wilhelm Ascellon Corporation 1/21/25 ACCEPTABLE 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A three (3) story with basement, 1967, Type II (111), protected noncombustible construction with 1984 and 1994 additions of the same construction type. The building has complete coverage by an automatic (wet) sprinkler system and a total of seven (7) smoke compartments. A Comparative Federal Monitoring Survey was conducted on 8/22/24, following a State Agency Annual Survey on 7/16/24, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, St. Joseph Villa was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.90 (a) et seq. (Life Safety from Fire).	K 000	POC for K 353 is comprised of the following: 1) Corrective action plan for all residents affected and potentially all residents affected by the deficiency: - Outside contractor AAA fire is replacing all 4 heads that needed to be replaced. Parts were ordered and installation is happening on 10/14. All other sprinkler heads were checked on 8/23 no other heads were deficient or needing to be replaced. 2) Measures put in place to ensure deficient practice does not re-occur: - Maintenance team will conduct monthly checks of all sprinkler heads to ensure they are in proper condition. Quarterly inspection to be conducted by AAA fire also to ensure proper condition of sprinkler heads. 3) The Maintenance Director will report any findings to the QA&A committee/QAPI on a quarterly basis or until substantial compliance is reached.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		10/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: administrator | (X6) DATE: 10/11/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. BUILDING **01 - ST. JOSEPH VILLA 0102** B. WING _____	**08/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH VILLA	**451 EAST BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 1 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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system. The deficient practice affected one (1) of seven (7) smoke compartments, staff, and no residents. The facility had the capacity for 221 beds with a census of 173 on the day of survey. The findings include: Observation during a tour of the building, on 8/22/24, at 3:22 p.m., revealed four (4) of four (4) sprinkler heads in the dishwashing area of the kitchen were observed to be covered with corrosion. The facility failed to maintain the sprinkler system with sprinkler heads free from corrosion as required by section 5.2.1.1.2 of NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview, on 8/22/24, at 3:22 p.m., with the Maintenance Director, revealed the facility staff	K 353		10/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. BUILDING 01 - ST. JOSEPH VILLA 0102 B. WING _____	08/22/2024

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ST JOSEPH VILLA	451 EAST BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115

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K 353	Continued From page 2 was not aware the sprinkler heads located in the dishwashing area of the kitchen were covered with corrosion. The census of 173 was verified by the Administrator on 8/23/24, at 10:19 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 8/22/24, at 4:29 p.m. Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.3.5 Extinguishment Requirements. 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: NFPA 13, Standard for the Installation of Sprinkler Systems Actual NFPA Standard: NFPA 13 Standard for the Installation of Sprinkler Systems (2010) Chapter 26 System Inspection, Testing, and Maintenance 26.1* General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained by the property owner or their authorized representative in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. BUILDING **01 - ST. JOSEPH VILLA 0102** B. WING _____	**08/22/2024**

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ST JOSEPH VILLA	**451 EAST BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115**

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K 353	Continued From page 3 Actual NFPA Standard: NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011) 5.2.2* Sprinkler pipe and fittings shall be inspected annually from the floor level. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer	K 353		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. BUILDING **01 - ST. JOSEPH VILLA 0102** B. WING _____	**08/22/2024**

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ST JOSEPH VILLA	**451 EAST BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115**

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K 372	Continued From page 4 Based on observation and interview, the facility failed to maintain the smoke barriers to resist the passage of smoke. The deficient practice affected two (2) of seven (7) smoke compartments, staff, and 24 residents. The facility had the capacity for 221 beds with a census of 173 on the day of survey. The findings include: Observation during a tour of the building, on 8/22/24, at 2:30 p.m., revealed the smoke barrier wall above the above the horizontal, sliding, fire door (WON brand door) on the first floor of the building had the following two (2) unsealed penetrations: 1. A two inch in diameter unsealed/ open penetration. 2. A two inch in diameter unsealed penetration for a metal clad cable. An interview, on 8/22/24, at 2:30 p.m., with the Maintenance Director revealed the facility was unaware of the two (2) unsealed penetrations in the smoke barrier above the WON door on the first floor of the building. The census of 173 was verified by the Administrator on 8/23/24, at 10:19 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 8/22/24, at 4:29 p.m. Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1?2-hour fire resistance rating, unless otherwise permitted by one (1) of	K 372	POC for K 372 is comprised of the following: 1) Corrective action plan for all residents affected and potentially all residents affected by the deficiency: - the smoke barrier wall above won door was patched and sealed on 8/23/24. There were no other holes in smoke barrier walls. 2) Measures put in place to ensure deficient practice does not re-occur: - Maintenance team will do a quarterly check or after any construction projects check to ensure there are no holes in smoke barrier walls. 3) Maintenance Director will report any findings to the QA&A committee/QAPI on a quarterly basis or until substantial compliance is reached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 5 the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two (2) separate smoke compartments shall be provided on each floor. (2) *Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the	K 372		

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	465095	A. BUILDING 01 - ST. JOSEPH VILLA 0102 B. WING _____	08/22/2024

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K 372	Continued From page 6 transfer of smoke. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. 8.5.6.5 Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be securely set in the smoke barrier, and the space between the item and the sleeve shall be filled with a material capable of restricting the transfer of smoke.	K 372		

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E 000	Initial Comments 42 CFR 483.73 K6 PLAN APPROVAL: 1967 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A three (3) story with basement, 1967, Type II (111), protected noncombustible construction with 1984 and 1994 additions of the same construction type. The building has complete coverage by an automatic (wet) sprinkler system and a total of seven (7) smoke compartments. A Comparative Federal Monitoring Survey was conducted on 8/22/24, following a State Agency Annual Survey on 7/16/24, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, St. Joseph Villa was found to not be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.73 et seq. (Emergency Preparedness).	E 000	Reviewed by Erik Wilhelm Ascellon Corporation 11/20/24 ACCEPTABLE	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2),	E 006		10/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: administrator | (X6) DATE: 10/11/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 006	Continued From page 1 §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(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 the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[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. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.	E 006	POC for E 006 is comprised of the following: 1) Corrective action plan for all residents affected and potentially all residents affected by the deficiency: - HVA plan was revised and elopement drill and procedure and policy included in the HVA plan on 8/23/24 2) Measures put in place to ensure deficient practice does not re-occur: - HVA plan was reviewed no other items were missing and will continue to review annually and update as needed. 3) The Maintenance Director will report any findings to the QA&A committee/QAPI on a quarterly basis or until substantial compliance is reached.	10/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 006	Continued From page 2 (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to develop an Emergency Preparedness (EP) plan with a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach, which included missing residents. The deficient practice affected seven (7) of seven (7) smoke compartments, staff, and all residents. The facility had the capacity for 221 beds with a census of 173 on the day of survey. The findings include: Records review of the facility's EP plan, on 8/22/24, at 4:01 p.m., revealed the facility's risk assessment did not include facility-based and community-based risks, including missing residents. The facility failed to provide documentation of a completed risk assessment that included all aspects of facility-bases and community-based risks, utilizing an all-hazard approach, which included missing residents, as required by the Code of Federal Regulations	E 006		

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E 006	Continued From page 3 (CFR) §483.73(a)(1):] (1). An interview with the Administrator and Maintenance Director, on 8/22/24, at 4:01 p.m., revealed the facility was not aware the risk assessment or hazard vulnerability assessment (HVA) was required to include missing residents. The census of 173 was verified by the Administrator on 8/23/24, at 10:19 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 8/22/24, at 4:29 p.m.	E 006		