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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2015 |
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| NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268 |
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| K 0000 Bldg. 01 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/31/15</p> <p>Facility Number: 000548 Provider Number: 155472 AIM Number: NA</p> <p>At this Life Safety Code survey, Hoosier Village was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19 Existing Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in support rooms and at smoke barrier and horizontal exit doors. The facility has smoke detectors hard wired to the building's electrical system in all</p> | K 0000 | The plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law. | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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| K 0038 SS=E Bldg. 01 | <p>resident sleeping rooms. The facility has a capacity of 24 and had a census of 16 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This</p> | K 0038 | <p>The code is accessible to all visitors and residents not requiring specialized security at the receptionist's desks. Further, a sign has been posted above the key pad with the code to the door. There are no other doors affected. To ensure ongoing compliance, the facility administrator will visualize that the code to the door is posted at the key pad on an ongoing basis. As a means of quality assurance, the administrator will review the door code is posted with the safety committee quarterly on an ongoing basis.</p> | 08/30/2015 |

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| K 0052 SS=F Bldg. 01 | <p>deficient practice could affect 10 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services during a tour of the facility from 11:20 a.m. to 1:30 p.m. on 07/31/15, the exit to Deercrest Hall was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Director of Environmental Services stated not all residents have a clinical diagnosis to be in a secure building and acknowledged the four digit code was not posted at the exit to Deercrest Hall. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of</p> | | | |

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| | <p>NFPA 70 and 72. 9.6.1.4</p> <p>1. Based on record review, observation, and interview; the facility failed to document annual functional testing of 61 of 61 single station smoke detectors installed in the facility. NFPA 72, 7-3.3 states single station smoke detectors installed in other than one- and two-family dwelling units shall be tested and maintained in accordance with Chapter 7. Table 7-3.2 requires all single station smoke detectors to be functional tested annually. Section 7-5.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Environmental Services from 9:15 a.m. to 11:20 a.m. on 07/31/15, documentation of annual testing of resident sleeping room smoke detectors was not available for review. Based on interview at the time of record review, the Director of Environmental Services stated resident sleeping room smoke detectors are hard wired to the building's electrical system and do not contain batteries as a secondary power supply. In addition, the Director of Environmental Services acknowledged documentation of</p> | K 0052 | <p>The fire alarm system is inspected and checked on an annual basis by the facilities contracted vendor. The batteries that were listed as 'fail' have been replaced. To ensure ongoing compliance all batteries have been tagged with the date and staff initials at time of replacement. As a means of quality assurance, all annual reports concerning fire alarm system inspections will be reviewed by the Director of Environmental Services or his designee immediately following inspections to ensure timely remedies listed on the report. Further, the inspections will be reviewed with the Safety committee team in the quarterly meetings on an ongoing basis.</p> | 08/30/2015 |

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| | <p>annual testing of resident sleeping room smoke detectors was not available for review. Based on observations with the Director of Environmental Services during a tour of the facility from 11:20 a.m. to 1:30 p.m. on 07/31/15, each of 61 resident sleeping rooms has a GENTEX smoke detector installed in the room which is hard wired to the building's electrical system and each smoke detector does not contain a battery as a secondary power supply. Based on Internet review of GENTEX Corporation 7000 and 8000 Series "Owners Information" manual on 08/04/15, information in regard to the required frequency of testing and cleaning GENTEX smoke detectors states to "refer to NFPA 72."</p> <p>3.1-19(a)</p> <p>2. Based on record review, observation and interview; the facility failed to document 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires an annual check of all fire alarm system batteries. Section 7-1.1.2 states system defects and malfunctions shall be corrected. NFPA 72, 7-5.2.2 states a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice</p> | | | |

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| | <p>could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Inspection & Test Report" documentation dated 01/07/13 and 12/16/14 with the Director of Environmental Services from 9:15 a.m. to 11:20 a.m. on 07/31/15, fire alarm system control panel batteries testing was listed as "Fail" for the two most recent documented fire alarm system inspection and test. In addition, the "Technician Comments" section stated "Batteries in healthcare main panel failed at last inspection and have not been replaced." Based on interview at the time of record review, the Director of Environmental Services stated a work order had been generated to replace the batteries but documentation of the replacement of the fire alarm system control panel batteries was not available for review and acknowledged the aforementioned inspection report listed the batteries as "Fail." Based on observation with the Director of Environmental Services during a tour of the facility from 11:20 a.m. to 1:30 p.m. on 07/31/15, the fire alarm system control panel batteries had no affixed documentation stating the age or installation date of the batteries.</p> | | | |

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| K 0064 SS=D Bldg. 01 | <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 9 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect two staff and visitors in the Laundry.</p> | K 0064 | <p>1. Portable fire extinguishers are checked monthly by facility maintenance staff and annually by a contract vendor company. The fire extinguisher located in the laundry area behind the washing machines will be relocated to a more visible and accessible area. To ensure ongoing compliance the Director of Environmental services or his designee will review all fire extinguisher reports. As a means of quality assurance the Director of Environmental Services or his designee will review his findings with the Safety committee team during the quarterly meetings on an ongoing basis. 2. The portable fire extinguisher located in the laundry area behind the washing machine will be relocated to a</p> | 08/30/2015 |

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| | <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services during a tour of the facility from 11:20 a.m. to 1:30 p.m. on 07/31/15, the inspection tag affixed to the portable fire extinguisher behind the washing machines in the Laundry room indicated January 2014 as the date the most recent annual maintenance was performed. Based on interview at the time of observation, the Director of Environmental Services stated no other annual fire extinguisher maintenance documentation for the Laundry room fire extinguisher was available for review and acknowledged the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve month period.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area portable fire extinguishers requiring a 12 year hydrostatic test were emptied and subjected to the applicable maintenance procedures every six years as required by NFPA 10, Standard for Portable Fire Extinguishers Chapter 4-4.3. Fire extinguishers passing the applicable 6-year requirement of 4-4.3 shall have the maintenance information</p> | | <p>more visible and accessible area. The one fire extinguisher in question will be tested and labeled appropriately by August 30th. To ensure ongoing compliance the Director of Environmental Services or his designee will review all fire extinguisher testing reports to verify yearly maintenance has been performed. As a means of quality assurance the Director of Environmental Services or his designee will review testing and findings with the Safety committee team during the quarterly meetings on an ongoing basis.</p> | |

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| | <p>recorded on a suitable metallic label or equally durable material having a minimum size of 2 inches by 3 1/2 inches. The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self destructive type when removal from a fire extinguisher is attempted. The label shall include the following information:</p> <p>(a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch.</p> <p>(b) Name or initials of person performing the maintenance and name of agency performing the maintenance.</p> <p>NFPA 10 at Section 4-4.4.2, Verification of Service (Maintenance or Recharging) requires each extinguisher that has undergone maintenance that includes internal examination or has been recharged shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done</p> | | | |

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| K 0147 SS=E Bldg. 01 | <p>by a hand punch. This deficient practice could affect two staff and visitors in the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services during a tour of the facility from 11:20 a.m. to 1:30 p.m. on 07/31/15, the portable fire extinguisher behind the washing machines in the Laundry room was manufactured in 2003 and had an affixed label and collar stating the most recent documented six year maintenance procedures were performed in January 2008. Based on interview at the time of observation, the Director of Environmental Services acknowledged it had been more than six years since the most recent six year maintenance procedures had been performed for the aforementioned portable fire extinguisher.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the</p> | K 0147 | The facility does not permit the | 08/30/2015 | |

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| | <p>facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 18 residents, staff and visitors in the vicinity of Room 312.</p> <p>Findings include:</p> <p>Based on observation with the Director of Environmental Services during a tour of the facility from 11:20 a.m. to 1:30 p.m. on 07/31/15, a Devilbiss "Compact Compressor" with an attached half mask for oxygen delivery to the resident in Room 312 was plugged into a power strip. Based on interview at the time of observation, the Director of Environmental Services acknowledged a power strip was being used as a substitute for fixed wiring for at the aforementioned location.</p> <p>3.1-19(b)</p> | | <p>use of power strips in place of fixed wiring. The nebulizer machine mentioned in 312 is an intermediately used machine and had not been used for several weeks and has since been removed from room 312 due to non-use. To ensure ongoing compliance staff training will be conducted to monitor for power strip usage by residents and their families. As a means of quality assurance, any issues of non-compliance with the use of power strips will be addressed and remedied on the spot. The Administrator will report all concerns addressed to the Safety committee at the quarterly meeting on an ongoing basis.</p> | |

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| K 0000 Bldg. 02 | <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/31/15</p> <p>Facility Number: 000548 Provider Number: 155472 AIM Number: NA</p> <p>At this Life Safety Code survey, Hoosier Village was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The nurses station near resident Room 127 and Room 128 was constructed in 2010 and was surveyed with Chapter 18 New Health Care Occupancies.</p> <p>The 2010 addition to the one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in support rooms and at smoke barrier and horizontal exit doors. The facility</p> | K 0000 | The plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law. | |

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| K 0052 SS=C Bldg. 02 | <p>has smoke detectors hard wired to the building's electrical system in all resident sleeping rooms. The facility has a capacity of 24 and had a census of 16 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review, observation and interview; the facility failed to document 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires an annual check of all fire alarm system batteries. Section 7-1.1.2 states system defects and malfunctions shall be corrected. NFPA 72, 7-5.2.2 states a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice could</p> | K 0052 | The fire alarm system is inspected and checked on an annual basis by the facilities contracted vendor. The batteries that were listed as 'fail' have been replaced. To ensure ongoing compliance all batteries have been tagged with the date and staff initials at time of replacement. As a means of quality assurance, all annual reports concerning fire alarm system inspections will be reviewed by the Director of Environmental Services or his designee immediately following inspections to ensure timely | 08/30/2015 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2015 |
|--|---|---|---|

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|---|---|
| NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268 |
|---|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Inspection & Test Report" documentation dated 01/07/13 and 12/16/14 with the Director of Environmental Services from 9:15 a.m. to 11:20 a.m. on 07/31/15, fire alarm system control panel batteries testing was listed as "Fail" for the two most recent documented fire alarm system inspection and test. In addition, the "Technician Comments" section stated "Batteries in healthcare main panel failed at last inspection and have not been replaced." Based on interview at the time of record review, the Director of Environmental Services stated a work order had been generated to replace the batteries but documentation of the replacement of the fire alarm system control panel batteries was not available for review and acknowledged the aforementioned inspection report listed the batteries as "Fail." Based on observation with the Director of Environmental Services during a tour of the facility from 11:20 a.m. to 1:30 p.m. on 07/31/15, the fire alarm system control panel batteries had no affixed documentation stating the age or installation date of the batteries.</p> | | <p>remedies listed on the report. Further, the inspections will be reviewed with the Safety committee team in the quarterly meetings on an ongoing basis.</p> | |

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

PRINTED: 08/20/2015
FORM APPROVED
OMB NO. 0938-0391

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| | 3.1-19(b) | | | | |