

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/10/2015
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NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST DEMOTTE, IN 46310
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(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
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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: 08/10/15</p> <p>Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630</p> <p>At this Life Safety Code survey, Oak Grove Christian Retirement Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building identified as the Shepard's Care and Skilled units was located on the southeast and southwest wings of the first floor, built prior to March 1, 2003, and surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The facility is located on the first floor of a two story fully sprinklered building of Type V (111) construction. The facility</p>	K 0000	<p>This Plan of Correction constitutes the written allegation of 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 requirements established by state and federal law. Oak Grove Christian Retirement Village desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on September 9, 2015. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</p>	
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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 0025 SS=D Bldg. 01	<p>has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 59 and had a census of 34 at the time of this survey.</p> <p>All areas where the residents have customary access and areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and 1 of 1 smoke barrier walls were maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice is in staff only areas.</p>	K 0025	<p>It is the policy of this facility to ensure that all ceiling and wall smoke barriers are maintained to provide a one hour fire resistance rating. I. Specific Corrective Actions: a) The quarter inch corridor penetration around the pipe in the storage room on the old Oak Leaf unit will be properly sealed with proper rated fire retardant caulking/sealant. b) The one inch</p>	09/09/2015

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K 0062 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observations with the Plant Manager on 08/10/15 from 11:43 a.m. to 2:27 p.m., the following smoke barrier wall penetration and unsealed ceiling penetrations were discovered:</p> <p>a) a quarter inch corridor penetration around pipe in the Storage room in Old Oak Leaf.</p> <p>b) one inch corridor penetration around cables in the Old Nurse's Station.</p> <p>c) eleven ceiling penetrations ranging from one quarter inch to two square feet in the Alarm Panel room.</p> <p>Based on interview at the time of each observation, the Plant Manager acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the</p>	K 0062	<p>corridor penetration around the cables in the old Nurses' Station will be properly sealed with proper rated fire retardant caulking/sealant. c) The eleven ceiling penetrations in the Alarm Panel room will be properly sealed with the proper ceiling tile and with proper rated fire retardant caulking/sealant. II. Identification and correction of others: All other smoke barrier walls and ceilings will be checked and be properly sealed as applicable. III. Systemic Changes: All maintenance staff will attend an in-service reviewing properly sealing any opening created by pipes, cables or ceiling penetrations; including the use of properly rated ceiling tiles. Documentation will be kept on all materials used in order to prove their fire barrier capability. IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all smoke barrier walls and ceilings are checked and any pipe, cable or ceiling penetrations are properly sealed. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to</p>	09/09/2015	

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K 0130 SS=E Bldg. 01	<p>facility failed to replace 1 of 5 painted sprinkler heads in the Wellness Center. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and up to 5 residents.</p> <p>Findings include:</p> <p>Based on observation on 08/10/15 at 11:15 a.m., the Plant Manager confirmed the Wellness Center sprinkler head was covered in paint. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls was maintained to</p>	K 0130	<p>ensure automatic sprinkler systems are continuously maintained in reliable operating condition. I. Specific Corrective Actions: The painted sprinkler head in the Wellness Center will be replaced with an unpainted sprinkler head. II. Identification and correction of others: All sprinkler heads throughout the facility will be checked to ensure none have paint on them. III. Systemic Changes: All maintenance staff will attend an in-service reviewing not getting paint on sprinkler heads and if it does occur to clean the paint off or replace the sprinkler head. IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all sprinkler heads are maintained in a reliable operating condition. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to ensure the penetration in fire barrier walls are maintained to ensure the fire resistance of the</p>	09/09/2015

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	<p>ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 3 of 4 smoke compartments.</p>		<p>barrier. I. Specific CorrectiveActions: The fire barrier wall in Old Therapy will be sealed with an approved fire barrier caulk and other penetrations will be sealed with an approved wallboard joint compound. The attic fire barrier wall in New Therapy and any other penetrations will be sealed using an approved fire barrier caulk/sealant. II. Identification and correction of others: All fire barrier walls will be checked to ensure any penetrations are sealed with an approved material that maintains the fire resistance of the barrier.</p> <p>III. Systemic Changes: All maintenance staff will attend an in-service to review sealing penetrations in fire barrier walls with an approved fire barrier caulk/sealant. Documentation will be kept on all materials used in order to prove their fire barrier capability. IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all fire barrier walls are checked and any penetrations are properly sealed. The checks will then decrease to monthly for six months.</p>		

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K 0143 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on an observation with the Plant Manager on 08/10/15 at 3:04 p.m. then again at 3:10 p.m., the fire barrier wall in Old Therapy had four unsealed penetration measuring one quarter inch to one inch above the drop ceiling. Other penetrations were sealed with unapproved wallboard joint compound. Then again the attic fire barrier wall in New Therapy had a one quarter inch penetration around conduit above the drop ceiling. The Plant Manager failed to provide documentation for the other penetrations that were sealed with brown caulk and orange expandable foam. Based on interview at the time of observation, the Plant Manager acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete</p>			

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	<p>flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 08/10/15 at 1:46 p.m., the oxygen transferring room with at least four large liquid oxygen cylinders had one electrical switch on the wall four feet above the floor. One of the electrical outlets was less than two inches away from the top of the liquid oxygen cylinders. Based on an interview at the time of observation, The Plant Manager acknowledged the aforementioned</p>	K 0143	<p>It is the policy of this facility to ensure oxygen storage/transfer locations are maintained properly; including electrical fixtures, switches and outlets being installed in locations not less than 5feet above the floor to avoid physical damage.</p> <p><u>I. Specific CorrectiveActions:</u> The electrical switch located at four feet above the floor will be removed and relocated at least five feet above the floor. The electrical outlet will be removed and a solid cover plate installed.</p> <p><u>II. Identification andcorrection of others:</u> There are no other oxygen storage/transfer locations.</p> <p><u>III. Systemic Changes:</u> All maintenance staff will attend an in-service to review the proper location of electrical switches and outlets in an oxygen storage/transfer location.</p> <p><u>IV. Monitoring:</u> The plant manager or designee will do weekly checks, for one month, to ensure all electrical switches and outlets in the oxygen storage/transfer room are at least five feet above the floor. The checks will then decrease to monthly forsix months.</p>	09/09/2015

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K 0147 SS=E Bldg. 01	<p>condition.</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 facility failed to ensure 6 of 6 flexible cords and 3 of 3 multiplug adapters were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 3 residents.</p> <p>Findings include:</p> <p>Based on observation with Plant Manager on 08/10/15 between 11:12 a.m. to 2:28 p.m. the following was discovered:</p> <p>a) an extension cord powering a lamp and an extension cord powering a coffee pot in the Administrators office.</p> <p>b) an extension cord powering a cell phone charger and a multiplug adapter powering a coffee pot in the Marketing office.</p>	K 0147	<p>It is the policy of this facility to ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2.</p> <p>I. Specific Corrective Actions:</p> <p>a) The extension cords in the Administrators office were removed. b) The extension cord and multi-plug adaptor in the Marketing office were removed. c) The extension cord in the Therapy Nurse's Station was removed. d) The multi-plug powering the lamp in resident room 121 was removed. e) The power strips were removed from resident room 126. f) The multi-plug extension cord powering the microwave in the Staff Break Room was removed.</p> <p>II. Identification and correction of others: All areas/rooms were checked to ensure that extension cords and/or multi-plug adaptors were not in use.</p> <p>III. Systemic Changes: All maintenance staff will attend an in-service reviewing the prohibited use of extension cords and multi-plug adaptors. IV. Monitoring: The plant manager</p>	09/09/2015			

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K 0160 SS=D Bldg. 01	<p>c) an extension cord powering two cell phone chargers in the Therapy Nurse's Station.</p> <p>d) a multiplug powering a lamp in resident room 121.</p> <p>e) a power strip powering another power strip powering a lamp in resident room 126.</p> <p>f) a multiplug extension cord powering a microwave in Staff Break Room.</p> <p>Based on interview at the time of observation, the Plant Manager acknowledged each of the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview; the facility failed to ensure 1 of 1 elevator equipment rooms was provided with an electrical shunt trip when provided with sprinkler coverage. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in</p>	K 0160	<p>or designee will do weekly checks, for one month, to ensure extension cords and/or multi-plug adaptors are not in use. The checks will then decrease to monthly for six months.</p> <p>It is the policy of this facility to comply with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p><u>I. Specific Corrective Actions:</u> The elevator equipment room will be provided with an electrical shunt trip. <u>II. Identification and correction of others:</u> There is</p>	09/09/2015	

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K 0000 Bldg. 03	<p>elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon or prior to the application of water from the sprinkler located in the elevator machine room. This deficient practice would affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Plant Manager on 08/10/15 at 11:41 a.m., the elevator equipment room contained 1 sprinkler head and a smoke detector. Based on interview at the time of observation, the Director of Maintenance acknowledged the aforementioned condition and confirmed the elevator equipment room did not have an elevator shunt trip.</p> <p>3.1-19(b)</p> <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: 08/10/15</p>	K 0000	<p>only one elevator equipment room.</p> <p>III. Systemic Changes: All maintenance staff will attend an in-service reviewing the need for an electrical shunt trip in a sprinkled elevator equipment room. IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure the electrical shunt trip is installed. The checks will then decrease to monthly for six months.</p> <p>This Plan of Correction constitutes the written allegation of 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 requirements</p>				

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	<p>Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630</p> <p>At this Life Safety Code survey, Oak Grove Christian Retirement Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2013 Oak Leaf Rehabilitation Unit was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The Oak Leaf Unit is a one story fully sprinklered building of Type V (111) construction. The addition has a fire alarm system with hard wired smoke detection in the resident rooms and in the corridor at the horizontal exit. The facility has the capacity for 59 and had a census of 34 at the time of this survey.</p> <p>All areas where the residents have customary access and areas providing facility services were sprinklered.</p>		<p>established by state and federal law. Oak Grove Christian Retirement Village desires this Plan ofCorrection to be considered the facility's Allegation of Compliance. Compliance is effective on September 9, 2015. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</p>		