

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155611	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/05/2016
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NAME OF PROVIDER OR SUPPLIER HOOSIER CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 621 S SUGAR ST BROWNSTOWN, IN 47220
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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: 05/05/16</p> <p>Facility Number: 000277 Provider Number: 155611 AIM Number: 100290530</p> <p>At this Life Safety Code survey, Hoosier Christian Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 97 and had a census of 97 at the time of this visit.</p>	K 0000	<p>Please consider this plan of correction as Hoosier ChristianVillage's credible plan of correction. This plan of correction constitutes a written allegation of substantialcompliance under Federal and Medicare requirements. Submission of this plan of correction is notan admission that a deficiency exists or that the community agrees they wererecited correctly. This plan ofcorrection reflects a desire to continuously enhance the quality of care andservices provided to our residents solely as a requirement of the provision offederal and State law. Please acceptthis evidence in lieu of an onsite follow-up for recertification and statelicensure survey event ID IY4B21 on May 5, 2016.</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 0018 SS=D Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which were not sprinkled.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 22 Service Hall corridor doors was provided with a suitable means for keeping the door closed. This deficient practice affects no residents and staff only who work in the Service Hall.</p>	K 0018	<p>1.No residents were affected by this deficientpractice.</p> <p>2.No residents have the potential to be affectedby this deficient practice.</p> <p>3.On May 13, 2016, the Service Hall employee lungeroom corridor door was repaired to include latching hardware.</p>	05/13/2016

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K 0025 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation on 05/05/16 at 10:20 a.m. with the maintenance supervisor, the Service Hall employee lounge room corridor door lacked latching hardware. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 05/05/16 at 12:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 9 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 4 residents who reside on the Beauty Shop Hall in resident rooms 114 and 115.</p> <p>Findings include:</p>	K 0025	<p>4. The maintenance supervisor will do monthly audits to ensure all doors within Hoosier Christian Village contain latching hardware. These audits will be brought to the CQI committee for further review and recommendations.</p> <p>5. Date completed : May 13, 2016.</p> <p>1. No residents were affected by this deficient practice.</p> <p>2. Four residents have the potential to be affected by this. On May 13, 2016, the three inch gap was repaired and filled in around the cable bundle penetration and fire stopped. On May 16, 2016, the beauty shop hall smoke barrier wall one inch gap was filled around the electrical conduit penetration and fire stopped.</p>	05/13/2016

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K 0027 SS=E Bldg. 01	<p>Based on observations with the maintenance supervisor on 05/05/16 during observations of the smoke barrier walls above the drop ceiling assembly from 11:50 p.m. to 12:20 p.m., the following smoke barrier walls had penetrations not fire stopped;</p> <p>a. The Service Hall smoke barrier wall by the maintenance office had a three inch gap around a cable bundle penetration not fire stopped.</p> <p>b. The Beauty Shop Hall smoke barrier wall had a one inch gap around a electrical conduit penetration not fire stopped.</p> <p>The Service Hall attic smoke barrier penetration and Beauty Shop Hall smoke barrier penetration was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 05/05/16 at 12:45 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required</p>		<p>3.The maintenance supervisor will do monthly audits during his environmental round to ensure all smoke barriers have no gaps and are fire stopped. These audits will be brought to the CQI committee for further review and recommendations.</p> <p>4. These audits will be monitored and reviewed by the CQI committee ongoing.</p> <p>5. Date completed : May 13, 2016.</p>				

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K 0029	<p>to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 9 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect 8 residents who reside on Chapel Hall in rooms 312, 313, 314 and 315.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 05/05/16 at 11:35 a.m., the Chapel Hall set of smoke barrier doors had a two inch gap between the doors in the closed position where the doors came together in the closed position. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 05/05/16 at 12:45 p.m.</p> <p>3.1-19(b) NFPA 101</p>	K 0027	<p>1.No residents were affected by this deficientpractice.</p> <p>2.Eight residents have the potential to beaffected by this. On May 17, 2016, theChapel Hall set of smoke barrier doors were repaired to eliminate the two inchgap between the doors in the closed position where the doors came together.</p> <p>3.The maintenance supervisor will do monthlyaudits during his environmental rounds to ensure all smoke barrier doors do not contain a gap between the doorswhen in a closed position. These auditswill be brought to the CQI committee for further review and recommendations.</p> <p>4.These audits will be monitored and reviewed bythe CQI committee ongoing.</p> <p>5.Date completed: May 17, 2016</p>	05/17/2016

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SS=D Bldg. 01	<p>LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 Service Hall hazardous areas, such as a combustibile storage room over 50 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects no residents and staff only who work in the Service Hall.</p> <p>Findings include:</p> <p>Based on observation on 05/05/16 at 10:50 a.m. with the maintenance supervisor, the Service Hall laundry storage room, which measured one hundred ten square feet and stored six shelves of twelve cardboard boxes of clothing, had a door that lacked a self closing device and latching hardware. This was verified by the maintenance supervisor at the time of observation and</p>	K 0029	<p>1.No residents were affected by this deficientpractice. 2.No residents have the potential to be affectedby this. On May 18, 2016, The ServiceHall laundry storage room, which measured one hundred ten square feet and storedsix shelves of twelve cardboard boxes of clothing, had the door repaired toinclude a self-closing device and latching hardware. 3.The maintenance supervisor will do monthlyaudits during his environmental rounds to ensure all necessary doors contain a self-closing device and latching hardware. These audits will be brought to the CQI committee for further review andrecommendations. 4.The audits will be monitored and reviewed by theCQI committee ongoing. 5.Date completed : May 18, 2016</p>	05/18/2016	

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

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FORM APPROVED
OMB NO. 0938-0391

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	acknowledged by the administrator at the exit conference on 05/05/16 at 12:45 p.m. 3.1-19(b)				