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 02/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER CHRISTIAN VILLAGE	621 S SUGAR ST BROWNSTOWN, IN 47220

(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
K010000	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). Survey Date: 02/04/14 Facility Number: 000277 Provider Number: 155611 AIM Number: 100290530 Surveyor: Mark Bugni, Life Safety Code Specialist 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. 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, in spaces open to the corridors and battery operated smoke	K010000	Please consider this plan of correction as Hoosier Christian Village's credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare and Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	detectors in all resident sleeping rooms. The facility has a capacity of 97 and had a census of 94 at the time of this visit. All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except two detached wooden storage sheds. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/10/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of 108 corridor doors would latch and resist the passage of smoke with no impediment to closing the doors. This deficient practice affects no residents since the North Hall minimum data set office and North Hall lift storage room are staff only areas. Findings include: Based on observations on 02/04/14 during a tour of the North Hall from 10:10 a.m. to 10:50 a.m. with the maintenance supervisor, the minimum data set office and lift storage room corridor doors each had between a one half inch and one inch gap along the top and latching sides of the doors with the	K010018	1. On 2/13/14, new metal/rubber door trim was installed to the two corridor doors to ensure they would latch and resist the passage of smoke with no impediment to closing the doors.2. No residents were found to be affected by this alleged deficient practice.3. Upon environmental rounds, the maintenance supervisor will audit all corridor doors to ensure they latch and resist the passage of smoke with no impediment to closing the doors.4. The maintenance supervisor will repair any corridor doors not latching and resisting smoke passage properly, and report to the CQI committee for further review and recommendations.5. The systemic changes were completed 2/13/14.	02/13/2014

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	doors closed. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the 1:30 p.m. exit conference on 02/04/14. 3.1-19(b)			
K010025 SS=E	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 Based on observation and interview, the facility failed to ensure 5 of 8 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 16 residents who reside on the 330 Hall, 16 residents who reside on the 130 Hall and 16 residents who reside on the 110 Hall. Findings include: Based on observations with the maintenance supervisor on 02/04/14	K010025	1. On 2/14/14, new fire caulk was placed into the 5 attic smoke barriers to ensure they are constructed to provide at least a one half hour fire resistance rating.2. Residents have the potential to be affected by this alleged deficient practice. All attic smoke barriers will continue to be audited, and checked, by the maintenance supervisor on a semi-annual basis.3. Smoke barriers will be audited on a semi-annual basis by the maintenance supervisor. Any findings will be immediately repaired and brought to the CQI	02/14/2014

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	during observations of the smoke barrier walls above the drop ceiling assembly from 12:10 p.m. to 1:00 p.m., the following smoke barrier walls had penetrations which were not fire stopped; a. 330 Hall north smoke barrier wall had a two inch penetration from a cable bundle not fire stopped. b. The Service Hall smoke barrier wall had a two inch penetration from a cable bundle not fire stopped. c. The 130 Hall first south smoke barrier wall by room 137 had a three inch penetration from a cable bundle not fire stopped. d. The 130 Hall second south smoke barrier wall by room 131 had a two inch penetration from a cable bundle not fire stopped. e. The 110 Hall smoke barrier wall by room 115 had a two inch by four inch area of drywall missing in the center of the smoke barrier wall. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/04/14 at 1:30 p.m. 3.1-19(b)		committee for further review and recommendations. 4. The CQI committee will review Maintenance supervisor's semi-annual audits to ensure the smoke barriers are constructed to provide at least a one half hour fire resistance rating. 5. The systemic changes were completed on 2/14/14.	

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K010027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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 to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires 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 16 residents who reside on 110 Hall. Findings include: Based on observation with the maintenance supervisor on 02/04/14 at 1:10 p.m., the 110 Hall west set of smoke barrier doors had a three foot gap between the doors in the closed position where the south door was hitting the	K010027	1. On 2/12/14, the 110 Hall west set of smoke barrier doors were adjusted by a professional to ensure the doors would restrict the movement of smoke for at least 20 minutes. The opening was closed leaving only the minimum clearance necessary for proper operation to restrict the movement of smoke.2. Residents have the potential to be affected by this alleged deficient practice. The maintenance supervisor will conduct monthly audits to ensure that all sets of smoke barrier doors will restrict the movement of smoke for at least 20 minutes.3. These monthly audits will continue, ongoing, with any findings to be immediately repaired.4. The maintenance supervisor will bring the audits and any findings or repairs to the CQI committee for further review and recommendations. 5. The systemic changes were completed 2/12/14.	02/12/2014

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	door coordinator. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the 1:30 p.m. exit conference on 02/04/14. 3.1-19(b)			
K010062 SS=E	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 Based on observation and interview, the facility failed to replace 2 of 2 sprinklers in the dishwashing room covered in corrosion. LSC 9.7.5 requires all automatic 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, 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 20 residents who use the main dining room, located adjacent to the kitchen. Findings include:	K010062	1. On 2/17/14, 2 sprinkler heads were installed in the dishwashing room. 2. Residents have the potential to be affected by this alleged deficient practice. 3. The maintenance supervisor will conduct monthly audits to ensure all sprinklers in the facility are not painted, corroded, damaged, loaded, and are in the proper orientation.4. The maintenance supervisor will replace any sprinklers identified to be painted, corroded, damaged, loaded or in the improper orientation immediately. Audits and any findings will be brought to the CQI committee for further review and recommendations.5. The systemic changes were completed on 2/17/14.	02/17/2014

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	Based on observation on 02/04/14 at 11:45 a.m. with the maintenance supervisor, the two sprinklers in the kitchen dishwashing room were both completely covered in green corrosion and dust. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/04/14 at 1:30 p.m. 3.1-19(b)			
K010130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire door was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A	K010130	1. On 2/18/14 the metal rolling fire door protecting the opening from the kitchen to the main dining room was inspected by the company Overhead Door. On 2/18/14, a locking collar was ordered to repair the door.2. Residents have the potential to be affected by this alleged deficient practice. 3. The metal rolling fire door protecting the opening from the kitchen to the main dining room, will be inspected and tested annually to check for proper operation and full closure. Resetting of the mechanism shall be done in accordance with the manufacturer's instructions. A written record will be maintained and made available for the authority having jurisdiction.4. These inspections will be kept	03/06/2014

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	written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 20 residents who use the main dining room, which is located adjacent to the kitchen rolling fire door. Findings include: Based on observation on 02/04/14 at 11:10 a.m. with the maintenance supervisor, there was a metal rolling fire door protecting the opening from the kitchen to the main dining room without an inspection tag. Based on interview on 02/04/14 at 11:30 a.m. with the maintenance supervisor, the rolling fire door has never been inspected. The lack of an annual rolling fire door inspection was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 02/04/14 at 1:30 p.m. 3.1-19(b)		and maintained. The maintenance supervisor will bring any findings to the CQI committee for further review and recommendations. Any needed repair will be completed upon finding.5. The systemic change will be completed on 3/6/14.	