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 08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER VILLAGE	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
K 0000 Bldg. 01	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: 08/02/16 Facility Number: 000548 Provider Number: 155472 AIM Number: NA 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. 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	K 0000	Hoosier Village is asking that this plan of correction submitted be considered for paper compliance. The plan of correction is submitted to meet the requirements established by the state and federal 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155472		08/02/2016

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	resident sleeping rooms. The facility has a capacity of 30 and had a census of 16 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 08/09/16 - DA			
K 0025 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an	K 0025	Each penetration of a smoke barrier has been remedied with construction materials of at least one hour fire resistance. No residents have been negatively affected. As a means to ensure ongoing compliance future penetrations of smoke barriers will be remedied at time of penetration. As a means of quality assurance a quarterly inspection of all smoke barriers will be performed by in-house personnel with results presented to the Safety committee meeting at the quarterly meetings.	08/19/2016

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	approved device designed for the specific purpose. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 13 residents, staff and visitors in the vicinity of the D Wing mechanical room. Findings include: Based on observations with the Environmental Services Director and the Maintenance Manager during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 08/02/16, the following was noted in the D Wing mechanical room: a. an open ended three inch in diameter vertically aligned PVC pipe penetrated the ceiling smoke barrier and was not filled with a material capable of maintaining the smoke resistance of the smoke barrier. b. a two inch in diameter hole in the ceiling smoke barrier for the passage of two cables was not filled with a material capable of maintaining the smoke resistance of the smoke barrier. c. the one half inch annular space surrounding a three inch in diameter pipe which penetrated the ceiling smoke			

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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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	barrier was not filled with a material capable of maintaining the smoke resistance of the smoke barrier. Based on interview at the time of the observations, the Environmental Services Director and the Maintenance Manager acknowledged the aforementioned openings in the D Wing mechanical room ceiling smoke barrier were not filled with a material capable of maintaining the smoke resistance of the ceiling smoke barrier. 3.1-19(b)			
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 Based on observation and interview, the facility failed to ensure 1 of 21 hazardous areas such as fuel fired heater rooms were separated from other areas by smoke resistant partitions. This deficient practice could affect 13 residents, staff and visitors in the vicinity of the D Wing mechanical room.	K 0029	Each penetration of a smoke barrier has been remedied with construction materials of at least one hour fire resistance. No residents were negatively affected. As a means to ensure ongoing compliance future penetrations of smoke barriers will be remedied at time of penetration. As a means of	08/19/2016

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	Findings include: Based on observations with the Environmental Services Director and the Maintenance Manager during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 08/02/16, the following openings were noted in the ceiling of the D Wing mechanical room which contained two natural gas fired water heaters and one natural gas furnace: a. an open ended three inch in diameter vertically aligned PVC pipe penetrated the ceiling smoke barrier. b. a two inch in diameter hole for the passage of two cables. c. the one half inch annular space surrounding a three inch in diameter pipe which penetrated the ceiling smoke barrier. Based on interview at the time of the observations, the Environmental Services Director and the Maintenance Manager acknowledged the aforementioned openings in the D Wing mechanical room ceiling smoke barrier did not separate this area from other areas by smoke resistant partitions. 3.1-19(b)		quality assurance a quarterly inspection of all smoke barriers will be performed by in-house personnel with results presented to the Safety committee meeting at the quarterly meetings.	
K 0050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			
	1. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Check Sheet" documentation with the Environmental Services Director and the Maintenance Manager during record	K 0050	The facility will conduct fire drills at unexpected times, under varying conditions and at least quarterly on each shift. There were no residents were adversely affected. To ensure ongoing compliance fire drills schedule has been revised to ensure fire drills are conducted at random times on each shift and the alarm is activated for all fire drills conducted on the 2nd shift if the drill is conducted before 9pm. The schedule will be maintained and reviewed by the maintenance manager quarterly. Fire drills will be logged and will be reviewed with the life safety committee meetings on a quarterly basis.	08/19/2016

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	review from 9:15 a.m. to 11:50 a.m. on 08/02/16, documentation for the second shift fire drill conducted on 06/11/16 at 3:30 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned fire drill stated "Silent Drill" in response to "What type of fire drill was conducted " and "N/A" in response to "Was Koorsen notified of fire drill?" Based on interview at the time of record review, the Environmental Services Director acknowledged documentation for the aforementioned fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. 3.1-19(b) 3.1-51(ac) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Check Sheet" documentation with the			

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	Environmental Services Director and the Maintenance Manager during record review from 9:15 a.m. to 11:50 a.m. on 08/02/16, four of five first shift (7:00 a.m. to 3:30 p.m.) fire drills conducted on 11/16/15, 01/12/16, 06/02/16 and 07/13/16 were conducted at, respectively, 11:00 a.m., 10:30 a.m., 11:00 a.m. and 11:00 a.m. Based on interview at the time of record review, the Environmental Services Director acknowledged the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)			
K 0062 SS=F Bldg. 01	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 record review and interview, the facility failed to ensure 2 of 4 automatic sprinkler systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents,	K 0062	The automatic sprinkler systems are maintained and in reliable operating condition. Hydro, a contracted company inspects and tests the system routinely. A Hydro technician had indicated on one of the inspections that the dry sprinkler system be flushed. On 8/10/16 the facility had a second contract company (Koorsen) come in and inspect the system. Koorsen's report specifies that flushing the system is not	08/19/2016

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	staff and visitors. Findings include: Based on review of Hydro Fire Protection "Internal Condition Inspection Report" documentation with the Environmental Services Director and the Maintenance Manager during record review from 9:15 a.m. to 11:50 a.m. on 08/02/16, an internal pipe inspection was conducted on 11/19/15 for the facility's four sprinkler systems. Two of the four sprinkler systems are dry sprinkler systems and the aforementioned internal pipe inspection stated "Yes" to " The sprinkler system piping and valve are in need of internal cleaning" and to "Was the piping and valve found to have foreign materials found in them." Additional comments on the aforementioned internal pipe inspection report were "Some mains were full of rust and foreign materials." Based on interview at the time of record review, the Environmental Services Director stated dry sprinkler systems flushing had not been performed on or after 11/19/15, no purchase agreement for sprinkler system flushing has been finalized as of the date of this survey and acknowledged sprinkler system flushing has not been performed or scheduled on or after 11/19/15.		required and not suggested. Documentation of the recommendation and the re-inspection is attached to the Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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	3.1-19(b)			
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 4 of 4 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 could affect 13 residents, staff and visitors in the vicinity of the Beauty Shop. Findings include: Based on observations with the Environmental Services Director and the Maintenance Manager during a tour of the facility from 1:00 p.m. to 2:50 p.m. on 08/02/16, the following was noted in the Beauty Shop: a. each of three hair washing station	K 0147	The facility does not permit the use of power strips in place of fixed wiring. The power strips used in the beauty shop have been removed immediately. No residents were adversely affected. As a means to ensure ongoing compliance a contract electrician will be installing additional dedicated electrical outlets. To ensure ongoing compliance staff training will be conducted to monitor for power strip usage in the beauty shop and all areas of the Health center. 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.	08/26/2016

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	consoles were equipped with an affixed power strip and a hair dryer was plugged into the middle console power strip and a second hair dryer was also plugged into a power strip in the console furthest from the corridor door. b. a power strip was plugged into a power strip in the hair washing station console nearest the corridor door. Based on interview at the time of the observations, the Environmental Services Director acknowledged power strips were being used as a substitute for fixed wiring in the Beauty shop. 3.1-19(b)			
K 0000 Bldg. 02	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: 08/02/16 Facility Number: 000548 Provider Number: 155472 AIM Number: NA At this Life Safety Code survey, Hoosier Village was found not in compliance with Requirements for Participation in	K 0000	Hoosier Village is asking that this plan of correction submitted be considered for paper compliance. The plan of correction is submitted to meet the requirements established by the state and federal law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 08/02/2016
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	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. 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 has smoke detectors hard wired to the building's electrical system in all resident sleeping rooms. The facility has a capacity of 30 and had a census of 16 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 08/09/16 - DA			
K 0050 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire			

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	alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			
	1. Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Check Sheet" documentation with the Environmental Services Director and the Maintenance Manager during record	K 0050	The facility will conduct fire drills at unexpected times, under varying conditions and at least quarterly on each shift. There were no residents were adversely affected. To ensure ongoing compliance fire drills schedule has been revised to ensure fire drills are conducted at random times on each shift and the alarm is activated for all fire drills conducted on the 2nd shift if the drill is conducted before 9pm. The schedule will be maintained and reviewed by the maintenance manager quarterly. Fire drills will be logged and will be reviewed with the life safety committee meetings on a quarterly basis.	08/19/2016

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	review from 9:15 a.m. to 11:50 a.m. on 08/02/16, documentation for the second shift fire drill conducted on 06/11/16 at 3:30 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned fire drill stated "Silent Drill" in response to "What type of fire drill was conducted " and "N/A" in response to "Was Koorsen notified of fire drill?" Based on interview at the time of record review, the Environmental Services Director acknowledged documentation for the aforementioned fire drill conducted after 6:00 a.m. but before 9:00 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. 3.1-19(b) 3.1-51(ac) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Check Sheet" documentation with the			

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HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

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	Environmental Services Director and the Maintenance Manager during record review from 9:15 a.m. to 11:50 a.m. on 08/02/16, four of five first shift (7:00 a.m. to 3:30 p.m.) fire drills conducted on 11/16/15, 01/12/16, 06/02/16 and 07/13/16 were conducted at, respectively, 11:00 a.m., 10:30 a.m., 11:00 a.m. and 11:00 a.m. Based on interview at the time of record review, the Environmental Services Director acknowledged the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)			
K 0062 SS=F Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 2 of 4 automatic sprinkler systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents,	K 0062	The automatic sprinkler systems are maintained and in reliable operating condition. Hydro, a contracted company inspects and tests the system routinely. A Hydro technician had indicated on one of the inspections that the dry sprinkler system be flushed. On 8/10/16 the facility had a second contract company (Koorsen) come in and inspect the system. Koorsen's report specifies that flushing the system is not	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	X3) DATE SURVEY COMPLETED 08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	staff and visitors. Findings include: Based on review of Hydro Fire Protection "Internal Condition Inspection Report" documentation with the Environmental Services Director and the Maintenance Manager during record review from 9:15 a.m. to 11:50 a.m. on 08/02/16, an internal pipe inspection was conducted on 11/19/15 for the facility's four sprinkler systems. Two of the four sprinkler systems are dry sprinkler systems and the aforementioned internal pipe inspection stated "Yes" to " The sprinkler system piping and valve are in need of internal cleaning" and to "Was the piping and valve found to have foreign materials found in them." Additional comments on the aforementioned internal pipe inspection report were "Some mains were full of rust and foreign materials." Based on interview at the time of record review, the Environmental Services Director stated dry sprinkler systems flushing had not been performed on or after 11/19/15, no purchase agreement for sprinkler system flushing has been finalized as of the date of this survey and acknowledged sprinkler system flushing has not been performed or scheduled on or after 11/19/15.		required and not suggested. Documentation of the recommendation and the re-inspection is attached to the Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 08/02/2016

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	3.1-19(b)			