

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 08/27/2013
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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
K010000	<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: 08/27/13</p> <p>Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</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 built prior to March 1, 2003 identified as the Shepard's Care and Skilled unit located on the southeast and southwest wings of the first floor was 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</p>	K010000	<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 26, 2013. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</p>	

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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	<p>Type V (111) construction. The facility has a fire alarm system with hard wired smoke detection in the corridors, in resident rooms and in spaces open to the corridors. The facility has the capacity for 59 and had a census of 57 at the time of this survey.</p> <p>All areas where the residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/04/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure 57 of 57 smoke detectors had been sensitivity tested as required. NFPA 72 at 7-3.2.1 states, Detector sensitivity shall be checked within one year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where</p>	K010051	<p>K051It is the policy of this facility to ensure all smoke detectors are sensitivity tested as required. I. Specific Corrective Actions: The facility immediately contacted the company responsible to perform the sensitivity testing and scheduled a certified technician to perform the testing. II. Identification and correction of others: All residents have the potential to be affected by smoke detectors that are not sensitivity tested. All smoke detectors will have sensitivity testing before September 26, 2013. III. Systemic Changes:The Fire Safety Plan Policy and Procedure will be updated to state that Smoke Detector Sensitivity Testing will</p>	09/26/2013			

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	<p>nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of the fire system inspection and test records on 08/27/13 with the administrator at 2:10 p.m., the</p>		<p>occur prior to September of every odd numbered year. A copy of the recorded completed smoke detector sensitivity testing will be kept in the Facility Life Safety Binder and a copy provided to the administrator. IV. Monitoring: The plant manager will provide a copy of the completed smoke detector sensitivity testing at the next QAPI Meeting and explain the requirements. Smoke detector sensitivity testing will be completed prior to September of every odd year. Any variations or complications will be reported at monthly QAPI meetings for the seven months.</p>				

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	<p>contractor's system test dated 11/20/12 as the smoke detector sensitivity report had no sensitivity test information. The administrator immediately called the service contractor and the same report was faxed as evidence of the sensitivity inspection. The Notification Appliance Test Results section of the report noted the functional test had been done on all devices and the column for sensitivity test results was blank. The administrator acknowledged at the time of record review, no current sensitivity report had been produced.</p> <p>3.1-19(b)</p>			

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to provide the minimum separation between 2 of 2 commercial cooking appliances in the kitchen. NFPA 96, 9-1.2.3 requires deep fat fryers shall be installed with at least a 16 inch space between the fryer and surface flames from adjacent cooking equipment except where a steel or tempered glass baffle plate is installed at a minimum of eight inches in height between the adjacent appliances. This deficient practice could affect 5 kitchen staff.</p> <p>Findings include:</p> <p>Based on observation of the commercial cooking appliances in the kitchen with the administrator on 08/27/13 at 1:45 p.m., the minimum separation of 16 inches or separation by a steel or tempered glass baffle plate was not provided between the gas range and fryer located side by side. A review of the Pre-Engineered Restaurant Fire Suppression Systems Report dated 05/29/13 with the administrator at 1:55 p.m. on 08/27/13 noted, "no divider between fryer and stove." The administrator said at the time of observation, she was unaware of the requirement and had not been aware of</p>	K010069	<p>K069It is the policy of this facility to ensure cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 I. Specific Corrective Actions: The fryer was immediately relocated to a distance of 16 inches from the adjacent cooking equipment. II. Identification and correction of others: All kitchen staff and residents have the potential to be affected by incorrectly located commercial cooking appliances. All cooking appliances were inspected to ensure maintenance of minimum separation.III. Systemic Changes:A steel baffle plate of 8+ inches in height was installed on the deep fryer.IV. Monitoring: The Dietary manager or designee will do weekly checks, for one month, to ensure the baffle plate is in place. The checks will then decrease to monthly for six months.</p>	09/26/2013			

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	the notes on the report. 3.1-19(b)			

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K020000	<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: 08/27/13</p> <p>Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code, 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 and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), and 410 IAC 16.2. The Oakleaf unit was surveyed under Chapter 18, New 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 has a fire alarm system with hard wired smoke detection in the corridors, in resident rooms and in spaces open to the</p>	K020000	<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 26, 2013. The facility respectfully requests paper compliance. Please accept the attached as our credible allegation of compliance.</p>				

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	<p>corridors. The facility has the capacity for 59 and had a census of 57 at the time of this survey.</p> <p>All areas where the residents have customary access and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K030025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure openings through the smoke barrier wall of 1 of 1 Oak Leaf wing mechanical rooms were maintained to provide the 1 hour smoke resistance of the smoke barrier. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall, from a floor to a floor, from a a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling including interstitial spaces. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, be protected so that the space between the penetrating item and the smoke barrier shall be filled with an approved material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff, and</p>	K030025	<p>K025It is the policy of this facility to ensure that all openings through smoke barrier walls are properly sealed. I. Specific Corrective Actions: Conduit and pipe penetrations of the Oak Leaf unit will be properly sealed with rated fire retardant caulking/sealant. II. Identification and correction of others: All other smoke barrier walls 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 conduit or pipe. IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all smoke barrier walls are checked and any conduit/pipe penetrations are properly sealed. The checks will then decrease to monthly for six months.</p>	09/26/2013			

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	<p>18 residents in the Oak Leaf wing.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/27/13 at 12:35 p.m., six conduit and pipe penetrations of the Oak Leaf mechanical room wall were left unsealed. The administrator acknowledged at the time of observation, the penetrations had not been properly sealed.</p> <p>3.1-19(b)</p>			
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K030044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 Oak Leaf fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for Fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects occupants of the Oak Leaf wing with a census of 18 residents.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/27/113 at 12:00 p.m., the fire door set in the Oak Leaf wing was tested twice manually with the administrator. One door in the fire door set failed to latch each time the doors were released to close. The administrator acknowledged at the time of observation, the door was not latching.</p> <p>3.1-19(b)</p>	K030044	<p>K044 It is the policy of this facility to ensure horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5. I. Specific Corrective Actions: The Oak Leaf fire door will be adjusted to properly latch automatically. Fire doors are tested monthly. Documentation of fire doors operation will be recorded and available upon request. II. Identification and correction of others: All fire doors were checked for proper automatic latching. III. Systemic Changes: All maintenance staff will attend an in-service to review proper latching of fire doors. IV. Monitoring: The plant manager or designee will do weekly checks, for one month, to ensure all fire doors are latching properly. The checks will then decrease to monthly.</p>	09/26/2013			

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K030051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure 57 of 57 smoke detectors had been sensitivity tested as required. NFPA 72 at 7-3.2.1 states, Detector sensitivity shall be checked within one year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall</p>	K030051	<p>K051It is the policy of this facility to ensure all smoke detectors are sensitivity tested as required. I. Specific Corrective Actions: The facility immediately contacted the company responsible to perform the sensitivity testing and scheduled a certified technician to perform the testing. II. Identification and correction of others: All residents have the potential to be affected by smoke detectors that are not sensitivity tested. All smoke detectors will have sensitivity testing before September 26, 2013. III. Systemic Changes:The Fire Safety Plan Policy and Procedure will be updated to state that Smoke Detector Sensitivity Testing will occur prior to September of every odd numbered year. A copy of</p>	09/26/2013			

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	<p>be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method.</p> <p>(2) Manufacturer's calibrated sensitivity test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of the fire system inspection and test records on 08/27/13 with the administrator at 2:10 p.m., the contractor's system test dated 11/20/12 as the smoke detector sensitivity report had</p>		<p>the recorded completed smoke detector sensitivity testing will be kept in the Facility Life Safety Binder and a copy provided to the administrator. IV. Monitoring: The plant manager will provide a copy of the completed smoke detector sensitivity testing at the next QAPI Meeting and explain the requirements. Smoke detector sensitivity testing will be completed prior to September of every odd year. Any variations or complications will be reported at monthly QAPI meetings for the seven months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2013
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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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	<p>no sensitivity test information. The administrator immediately called the service contractor and the same report was faxed as evidence of the sensitivity inspection. The Notification Appliance Test Results section of the report noted the functional test had been done on all devices and the column for sensitivity test results was blank. The administrator acknowledged at the time of record review, no current sensitivity report had been produced.</p> <p>3.1-19(b)</p>			