STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155611	A. BUILDING -- B. WING	11/20/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/20/24 Facility Number: 000277 Provider Number: 155611 AIM Number: 100290530 At this Emergency Preparedness survey, Hoosier Christian Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 97 certified beds. At the time of the survey, the census was 86. Quality Review completed on 11/22/24	E 0000	Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare 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 solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure survey event ID 2LTV21.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/20/24 Facility Number: 000277 Provider Number: 155611 AIM Number: 100290530	K 0000	Please consider this plan of correction as Hoosier Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Krista Garrison	Administrator	12/06/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	155611	A. BUILDING 01 B. WING	11/20/2024

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	At this Life Safety Code survey, Hoosier Christian Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery powered smoke alarms in all resident sleeping rooms. The facility has a capacity of 97 and had a census of 86 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/22/24		were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure survey event ID 2LTV21.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect 7 staff. Findings include: Based on the facility tour and interview with the Environmental Services Director (ESD) and Human Resource Manager (HRM) on 11/20/24 between 1:45 p.m. and 4:30 p.m., the (1) dining room door into the kitchen (containing large trash	K 0321	No residents were found to be affected by this alleged deficient practice. On November 20,2024, the Environmental Services Director removed the bungee cords from the dining room door into the kitchen, and the storage room door into the kitchen. No residents have the potential to be affected by this alleged deficient practice. On November 20, 2024, the Environmental Services Director provided	11/20/2024

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	receptacles) and (2) the storage room door into the kitchen (greater than 50 square feet contained a number of combustible items) each failed to self-close and latch because they were being held open with bungie cords. This finding was acknowledged by the ESD and HRM at the time of discovery and again at the exit conference with each present. 3.1-19(b)		re-education to the culinary team to include that hazardous area doors, such as storage rooms, must be provided with properly working self-closing devices and not propped open in any way. On November 20, 2024, the Environmental Services Director conducted an audit throughout the community to ensure no doors were propped open and contained properly working self-closing devices. These audits will be conducted weekly, ongoing, with any concerns to be brought to the Quality assurance committee for further review and recommendations.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on the facility tour and interview with the Environmental Services Director (ESD) and Human Resource Manager (HRM) on 11/20/24 between 1:45 p.m. and 4:30 p.m., the (1) corridor door to Resident Room #342 failed to close and latch positively into the door frame. And (2) double set of doors near Resident Room #342 did not close and latch. The ESD acknowledged these doors did not close completely and latch due to the door dragging and becoming stuck on the	K 0363	No residents were found to be alleged by this alleged deficient practice. On November 20, 2024, the Environmental Services Director replaced the latches to the corridor door to resident room 342 and the double set of doors near resident room 342. Two residents have the potential to be affected by this alleged deficient practice, no other residents have the potential to be affected by this alleged deficient practice. On November 20, 2024, the Environmental Services Director conducted an audit throughout the community to ensure all corridor	11/20/2024

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	flooring when released from the magnetically controlled holder integrated into the fire alarm system. This finding was acknowledged by the ESD and HRM at the time of discovery and again at the exit conference with each present. 3.1-19(b)		doors have no impediment to closing and latching into the door frame and will resist the passage of smoke. These audits will continue weekly, ongoing, with any concerns to be brought to the Quality assurance committee for further review and recommendations.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's	K 0921	On November 20, 2024, Environmental Services Director contacted Safecare to conduct testing of all PCREE (Patient Care Related Electrical Equipment) to ensure physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed. Safecare conducted an assessment on December 6, 2024; to assess (see uploaded documents) and a date was scheduled for December 26, 2024 to conduct testing, see uploaded agreement. Residents have the potential to be affected by this alleged deficient practice. The Environmental Services Director will maintain a log of all PCREE and will ensure it is tested in accordance with regulation before being put into service and after any repair or modification. The Environmental Services Director will maintain the PCREE	12/26/2024

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	policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. The findings include: Based on records review, interview and facility tour with the Environmental Services Director (ESD) and Human Resource Manager (HRM) on 11/20/24 between 11:15 a.m. and 4:30 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The HRM stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. Both the ESD and HRM stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the ESD and HRM at the time of discovery and again at the exit conference with each present. 3.1-19(b)		log and bring to monthly QAPI meeting for review and ensure appropriate testing has been completed. Any concerns will be reviewed by the quality assurance committee for further review and recommendations.	