| 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 | 09/26/2022 |

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

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 09/26/22<br><br>Facility Number: 000277<br>Provider Number: 155611<br>AIM Number: 100290530<br><br>At this Emergency Preparedness survey, Hoosier Christian Village was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 97 certified beds. At the time of the survey, the census was 82.<br><br>Quality Review completed on 10/03/22<br><br>The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: | E 0000 | Please accept this plan of correction as Hoosier Christian Village's credible plan of correction. The 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 SCQN21. | |
| E 0041<br>SS=F<br>Bldg. -- | 482.15(e), 483.73(e), 485.625(e)<br>Hospital CAH and LTC Emergency Power<br>§482.15(e) Condition for Participation:<br>(e) Emergency and standby power systems.<br>The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. | | | |

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

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| | The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the | | | |

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| | Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013. | | | |

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| | (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..<br>Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2).<br><br>Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on record review on 09/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, there was documentation of an annual generator inspection dated 04/15/22, and a semi annual inspection dated 10/13/21 however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the | E 0041 | 1. On September 29, 2022, GenSet Service, LLC performed a routine full service on the diesel generator, replaced batteries, and conducted a fuel sample report. No residents were found to be affected by this alleged deficient practice.<br>2. On September 28, 2022, maintenance supervisor contacted GenSet Service, LLC to visit Hoosier Christian Village for a fuel sample report. On September 26, 2022, Administrator provided one: one education to maintenance supervisor to inform of requirement of an annual fuel quality test to be performed for diesel powered generator. On September 28, 2022, maintenance supervisor added the task reminder to the TELS program to include a task notification for an annual fuel quality test for diesel-powered generator.<br>3. On September 26, 2022, administrator provided one: one education to maintenance supervisor to inform of requirement of an annual fuel quality test to be performed for diesel powered generator. On September 28, 2022, maintenance supervisor added the task reminder to the | 09/29/2022 |

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| | time of record review, the Maintenance Supervisor stated the facility does have a diesel generator but after having spoken with the facility's generator inspection vendor it was determined that a fuel sample has not been taken by the current vendor.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. | | TELS program to include a task notification for an annual fuel quality test for diesel-powered generator.<br>4. The maintenance supervisor will bring testing logs to monthly QAPI meetings. Any concerns will immediately be brought to administrator and addressed in QAPI for further review and recommendations. | |
| K 0000<br><br>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).<br><br>Survey Date: 09/26/22<br><br>Facility Number: 000277<br>Provider Number: 155611<br>AIM Number: 100290530<br><br>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.<br><br>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 | K 0000 | Please accept this plan of correction as Hoosier Christian Village's credible plan of correction. The 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 SCQN21. | |

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| | powered smoke alarms in all resident sleeping rooms. The facility has a capacity of 97 and had a census of 82 at the time of this survey.<br><br>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered including the employee smoke shack.<br><br>Quality Review completed on 10/03/22 | | | |
| K 0200 SS=B Bldg. 01 | NFPA 101<br>Means of Egress Requirements - Other<br>Means of Egress Requirements - Other<br>List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>18.2, 19.2<br>Based on observation and interview, the facility failed to ensure 2 of 2 egress doors from the two public rest rooms, were not equipped with a locking device that would require the use of a key to unlock from the inside in the case of fire or other emergencies in accordance with LSC 7.1.10.1. This deficient practice could affect two residents, staff or visitors.<br><br>Findings include:<br><br>Based on observations on 09/26/22 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the two public rest rooms near the front lobby area were both equipped with locking devices that required the use of a key to open from the inside and the outside. Based on interview at the time of | K 0200 | 1. On September 27, 2022, maintenance supervisor equipped the two public restrooms with a locking device that does not require the use of a key to unlock from the inside in case of a fire. No residents were found to be affected by this alleged deficient practice.<br>2. On September 27, 2022, maintenance supervisor conducted an audit to ensure no other egress doors were equipped with a locking device that would require the use of a key to unlock from the inside in case of a fire. No other residents have the potential to be affected by this alleged | 09/27/2022 |

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| | observations, the Maintenance Supervisor agreed these doors could not be unlocked from the inside and the outside without the use of a key if locked.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | deficient practice.<br>3. On September 27, 2022, maintenance supervisor conducted an audit to ensure no other egress doors were equipped with a locking device that would require the use of a key to unlock from the inside in case of a fire. During environmental rounds, administrator and maintenance supervisor will continue to ensure no egress doors are equipped with locking devices that require the use of a key to lock from the inside.<br>4. Any concerns from environmental rounds will be brought to monthly QAPI meetings for further review and recommendations. | |
| K 0324<br>SS=F<br>Bldg. 01 | NFPA 101<br>Cooking Facilities<br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. | | | |

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| | Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br>Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 edition, Section 11-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect mostly kitchen staff, plus residents in the adjacent dining room.<br><br>Findings include:<br><br>Based on record review on 9/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, there was no documentation available to show the kitchen range hood extinguishing system was inspected within the six months after the 01/05/22 inspection. The 01/05/22 range hood extinguishing system inspection report was the only report available during the past 12 month period. Based on interview at the time of record review, the Maintenance Supervisor said the 01/05/22 inspection report was the only range hood extinguishing system inspection report available for review during the past twelve month period.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | K 0324 | 1. On September 27, 2022, maintenance supervisor contacted Koorsen Fire and Security to conduct an inspection of the hood extinguishing system in the kitchen. On September 26, 2022, administrator provided one: one education to maintenance supervisor regarding the requirement to ensure hood-extinguishing systems in the kitchen are inspected and serviced every six months.<br>2. On September 27, 2022, maintenance supervisor contacted Koorsen Fire and Security to conduct an inspection of the hood extinguishing system in the kitchen. On October 4, 2022, an inspection was conducted of the hood extinguishing system in the kitchen. No residents were found to be affected by this alleged deficient practice.<br>3. On October 4, 2022, an inspection was conducted of the hood extinguishing system in the kitchen. On September 28, 2022, maintenance supervisor added a task reminder to the TELS program to include notification of task for inspection of hood extinguishing systems in the kitchen every six months. | 10/04/2022 |

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| | | | Maintenance supervisor will bring all tasks in TELS program to monthly QAPI meeting for review and recommendations.<br>4. Maintenance supervisor will bring all tasks in TELS report system to monthly QAPI meeting, any concerns will be brought the administrator and discussed for further review and recommendations. | |
| K 0341<br>SS=E<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Installation<br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br>Based on observation and interview, the facility failed to ensure 1 of 66 hard wired smoke detectors were not installed where air flow would adversely affect its operation. NFPA 72, 2010 edition, 17.7.6.3.2 requires that smoke detectors shall not be located directly in the airstream of supply registers. Section 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. A.17.7.4.1 states | K 0341 | 1. On September 27, 2022, maintenance supervisor relocated the smoke detector so that air flow would not adversely affect its operation. On September 27, 2022, maintenance staff conducted an audit to ensure no other smoke detectors in the facility were installed where air flow would adversely affect its | 09/27/2022 |

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| | detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. This deficient practice could affect at least 20 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations on 09/26/22 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was a ceiling mounted smoke detector in the corridor outside the 100 dining room within one foot of an air supply vent. Based on interview at the time of observation, the Maintenance Supervisor agreed the smoke detector was within one foot of the air supply vent.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | operation. No residents were found to be affected by this alleged deficient practice.<br>2. On September 27, 2022, maintenance supervisor relocated the smoke detector so that air flow would not adversely affect its operation. On September 27, 2022, maintenance staff conducted an audit to ensure no other smoke detectors in the facility were installed where air flow would adversely affect its operation.<br>3. During weekly environmental rounds, ongoing, maintenance supervisor will audit smoke detectors to ensure they are not installed where air flow would adversely affect its operation. Any concerns will be brought to the administrator for immediate action.<br>4. During weekly environmental rounds, ongoing, maintenance supervisor will audit smoke detectors to ensure they are not installed where air flow would adversely affect its operation. These audits will be brought to the monthly QAPI meeting for further review and recommendations. | |
| K 0345<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Testing and Maintenance<br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained | | | |

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| | in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>1. Based on record review and interview, the facility failed to ensure documentation was available to show that 66 of 66 smoke detectors were sensitivity tested within the past 24 months or prior. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:<br>(1) Calibrated test method.<br>(2) Manufacturer's calibrated sensitivity test instrument.<br>(3) Listed control equipment arranged for the purpose.<br>(4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.<br>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.<br>Detectors found to have sensitivity outside the | K 0345 | 1. On September 26, 2022, administrator provided one: one education to maintenance supervisor to include requirement of smoke detector sensitivity testing every alternate year after installation and a requirement of a visual semi-annual fire alarm system inspection. No residents were found to be affected by this alleged deficient practice.<br>2. On September 27, 2022, maintenance supervisor contacted Cintas to conduct a smoke detector sensitivity testing for all smoke detectors in facility. On September 28, 2022, maintenance supervisor conducted a visual fire alarm system inspection. On September 29, 2022, and October 4, 2022, Cintas conducted a smoke detector sensitivity test for all smoke detectors in Hoosier Christian Village.<br>3. On September 27, 2022, maintenance supervisor contacted Cintas to conduct a smoke detector sensitivity testing for all smoke detectors in facility. On September 28, 2022, maintenance supervisor conducted a visual fire alarm system inspection. On September 29, 2022, and October | 10/04/2022 |

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| | listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.<br>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility.<br><br>Findings include:<br><br>Based on record review on 09/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, the facility was unable to produce a smoke detector sensitivity report for all 66 smoke detectors for the past 24 month period or prior. Based on interview at the time of record review, the Maintenance Supervisor said he thought the smoke detector sensitivity testing had been performed within the past two years, but was unable to locate the documentation.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually:<br>a. Control unit trouble signals<br>b. Remote annunciators<br>c. Initiating devices (e.g. duct detectors, manual | | 4, 2022, Cintas conducted a smoke detector sensitivity test for all smoke detectors in Hoosier Christian Village. On September 28, 2022, maintenance supervisor added task reminders to the TELS program to include sensitivity testing for smoke detectors every alternate year, and a visual semi-annual fire alarm system inspection. Maintenance supervisor will bring all task reminders in the TELS program to monthly QAPI for review and recommendations.<br>4. Maintenance supervisor will bring all task reminders in the TELS program that are due or approaching a due date to monthly QAPI for further review and recommendations. | |

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| | fire alarm boxes, heat detectors, smoke detectors, etc.)<br>d. Notification appliances<br>e. Magnetic hold-open devices<br>This deficient practice could affect all occupants in the facility.<br><br>Findings include:<br><br>Based on record review on 09/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. The most recent annual fire alarm visual/functional test/inspection was dated 01/18/22. Based on interview at the time of record review, the Maintenance Supervisor said that a visual inspection of the fire alarm system's devices has not performed within six months after the 01/18/22 annual test/inspection.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | | |
| K 0353<br>SS=F<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.<br>Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____ | | | |

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| | b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review on 09/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, documentation of an internal inspection of the sprinkler system performed within the most recent five year period or prior was not available for review. Based on interview at the time of record review, the Maintenance | K 0353 | 1. On October 6, 2021, an automatic sprinkler piping system inspection was conducted for Hoosier Christian Village. On September 28, 2022, maintenance supervisor contacted Koorsen to replace the four sprinkler heads in the washer side of the laundry room and the two sprinkler heads in the dishwasher room. On September 29, 2022, Koorsen arrived to inspect the sprinkler heads in the laundry room and dishwasher room. On October 7, 2022, the sprinkler heads were replaced. On September 26, 2022, the spare sprinkler cabinet was organized to only hold six sprinkler heads placed in appropriate slots. On September 26, 2022, administrator provided one: one education to maintenance supervisor regarding sprinkler head routine checking, and organization of the spare sprinkler cabinet. No residents were found to be affected by this alleged deficient practice.<br>2. Maintenance supervisor will conduct weekly environmental rounds to ensure sprinkler heads show no signs of corrosion. | 10/07/2022 |

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| | Supervisor confirmed documentation of an internal inspection of the sprinkler system within the most recent five year period or prior was not available for review.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on observation and interview, the facility failed to ensure sprinkler heads in 1 of 10 smoke compartments covered with corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer.<br>This deficient practice could affect all resident, as well as laundry and kitchen staff within the smoke compartments.<br><br>Findings include:<br><br>Based on observations on 09/26/22 between 1:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted:<br>a. There were four sprinkler heads in the washer side of the laundry covered with corrosion.<br>b. There were two sprinkler head in the kitchen dishwasher room covered with corrosion.<br>Based on interview at the time of each | | These weekly rounds will be brought to monthly QAPI for further review. Any concerns will be brought immediately to the administrator for action. Maintenance supervisor will also bring all task reminders in the TELS program to monthly QAPI to ensure timely inspections are conducted.<br>3. Maintenance supervisor will conduct weekly environmental rounds to ensure sprinkler heads show no signs of corrosion. These weekly rounds will be brought to monthly QAPI for further review. Any concerns will be brought immediately to the administrator for action. Maintenance supervisor will also bring all task reminders in the TELS program to monthly QAPI to ensure timely inspections are conducted<br>4. Maintenance supervisor will bring weekly environmental round audits and all TELS program inspection task reminders to monthly QAPI meeting for further review and recommendations. Any concerns with the weekly audits will be brought immediately to the administrator for action and recommendations. | |

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| | observation, the Maintenance Supervisor agreed the previously mentioned sprinkler heads were covered with corrosion and should be replaced.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br><br>3. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems spare sprinkler cabinet was properly maintained. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility.<br><br>Findings include:<br><br>Based on observation on 9/26/22 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was a spare sprinkler cabinet in the riser room with at least twelve spare sprinkler heads inside, however, there were only six slots available for the spares. Six of the twelve sprinkler heads were laying and stacked loosely which could cause breakage to | | | |

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| | the sprinkler heads if falling out when opening the cabinet door. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the spare sprinkler cabinet was not large enough for the number of spare sprinkler heads in the current cabinet.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | | |
| K 0500<br>SS=F<br>Bldg. 01 | NFPA 101<br>Building Services - Other<br>Building Services - Other<br>List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on observation and interview, the facility failed to ensure 3 of 3 fuel-fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations on 09/26/22 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the three fuel-fired water heaters in the Mechanical Room had | K 0500 | 1. On October 5, 2022, the three fuel-fired water heaters inspection permits were purchased via Indiana Department of Homeland Security. On September 26, 2022, administrator provided one: one education to maintenance supervisor regarding requirement for renewal of inspection certificates to ensure water heaters are in safe operation condition. No residents were found to be affected by this alleged deficient practice.<br>2. On September 28, 2022, the maintenance supervisor added a task notification reminder to the | 10/05/2022 |

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| | certificates with an expiration date of 01/24/20. Based on interview at the time of observation the Maintenance Supervisor confirmed the expiration dates of the three fuel-fired water heaters.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | TELS program to include a reminder for renewal of inspection certificates to ensure water heaters are in safe operation condition.<br>3. On September 28, 2022, the maintenance supervisor added a task notification reminder to the TELS program to include a reminder for renewal of inspection certificates to ensure water heaters are in safe operation condition. Maintenance supervisor will bring the TELS report task reminders to monthly QAPI meeting to ensure all inspections and certificates are completed within the appropriate timeframe. On September 28, 2022, the maintenance supervisor added a task notification reminder to the TELS program to include a reminder for renewal of inspection certificates to ensure water heaters are in safe operation condition. Maintenance supervisor will bring the TELS report task reminders to monthly QAPI meeting to ensure all inspections and certificates are completed within the appropriate timeframe for further review and recommendations. | |
| K 0711<br>SS=F<br>Bldg. 01 | NFPA 101<br>Evacuation and Relocation Plan<br>Evacuation and Relocation Plan<br>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. | | | |

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| | Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.<br>18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3<br>Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:<br>(1) Use of alarms<br>(2) Transmission of alarm to fire department<br>(3) Emergency phone call to fire department<br>(4) Response to alarms<br>(5) Isolation of fire<br>(6) Evacuation of immediate area<br>(7) Evacuation of smoke compartment<br>(8) Preparation of floors and building for evacuation<br>(9) Extinguishment of fire<br>Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: | K 0711 | 1. Hoosier Christian Village does provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems. On September 26, 2022, administrator created an addendum to Hoosier Christian Village's Fire Watch Plan to include suggestions of surveyor. These items included a. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system and b. the removal of wheeled equipment from the corridor in the event of an emergency. No residents were found to be affected by this alleged deficient practice.<br>2. On September 26, 2022, administrator created an addendum to Hoosier Christian Village's Fire Watch Plan to include suggestions of surveyor. These items included a. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead | 09/26/2022 |

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| | i. Equipment in use and carts in use<br>ii. Medical emergency equipment not in use<br>iii. Patient lift and transport equipment<br>This deficient practice could affect all occupants in the event of an emergency.<br><br>Findings include:<br><br>Based on a review of the facility's "Fire Plan" on 09/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, the plan did not address the following items:<br>a. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system.<br>b. The removal of wheeled equipment from the corridor in the event of an emergency.<br>Based on interview at the time of record review, the Maintenance Supervisor acknowledged and agreed that the fire safety plan did not address the previously mentioned items.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | extinguishing system and b. the removal of wheeled equipment from the corridor in the event of an emergency.<br>3. Maintenance supervisor will bring the Emergency Preparedness Plan to monthly QAPI for review and recommendations. The Emergency Preparedness Plan will be reviewed thoroughly, annually, ongoing, by the Quality Assurance team.<br>Maintenance supervisor will bring the Emergency Preparedness Plan to monthly QAPI for review and recommendations. The Emergency Preparedness Plan will be reviewed thoroughly, annually, ongoing, by the Quality Assurance team. Any concerns will be addressed and reviewed in the QAPI meeting for further review and recommendations | |
| K 0761 SS=F Bldg. 01 | 1. Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings | K 0761 | 1. On September 27, 2022, maintenance supervisor conducted an inspection of the oxygen room fire door assembly. On September 28, 2022, Overhead Door Co. of SCI conducted a test of the rolling fire door. No residents were found to be affected by this alleged deficient | 09/28/2022 |

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| | required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.<br><br>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or | | practice. On September 26, 2022, administrator provided one: one education to maintenance supervisor regarding the requirement of a semi-annual inspection of the oxygen room fire door assembly and a test of the rolling fire door annually.<br>2. On September 27, 2022, maintenance supervisor conducted an inspection of the oxygen room fire door assembly. On September 28, 2022, Overhead Door Co. of SCI conducted a test of the rolling fire door.<br>3. On September 27, 2022, maintenance supervisor conducted an inspection of the oxygen room fire door assembly. On September 28, 2022, Overhead Door Co. of SCI conducted a test of the rolling fire door. Both the inspection of the oxygen room fire door assembly and the test of the rolling fire door were placed into the TELS program as task notification reminders by the maintenance supervisor on September 28, 2022. The oxygen room fire door assembly inspection will give a notification for every six months, and the rolling fire door testing will send notification for an annual inspection. The maintenance supervisor will bring these reports to monthly QAPI for further review. Any missed notifications will be brought to the administrator for immediate action. | |

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|---|---|---|---|
| | 155611 | A. BUILDING 01<br>B. WING | 09/26/2022 |

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

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| | frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect at least 20 residents, as well as staff, and visitors.<br><br>Findings include:<br><br>Based on record review on 09/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Supervisor said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Maintenance Supervisor between 12:10 p.m. and 2:30 p.m., there was one oxygen transfilling room fire door assembly noted in the facility.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b)<br><br>2. Based on record review, observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, | | 4. Both the inspection of the oxygen room fire door assembly and the test of the rolling fire door were placed into the TELS program as task notification reminder by the maintenance supervisor on September 28, 2022. The oxygen room fire door assembly inspection will give a notification for every six months, and the rolling fire door testing will send notification for an annual inspection. The maintenance supervisor will bring these reports to monthly QAPI for further review. Any missed notifications will be brought to the administrator for immediate action. All other reports will be reviewed in monthly QAPI for further review and recommendations. | |

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| | system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the dining room.<br><br>Findings include:<br><br>Based on record review on 09/26/22 between 9:15 a.m. and 12:10 p.m., there was no current annual rolling fire door inspection to review. The most recent inspection report to review was dated 05/19/21, which was also the most recent date on the tag on the rolling fire door. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the last annual test was 05/19/21 and said there were no other documents to review at the time of the survey.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | | |
| K 0918 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life | | | |

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| | safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) | | | |
| | Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators.<br>NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be | K 0918 | 1. On September 29, 2022, GenSet Service, LLC performed a routine full service on the diesel generator, replaced batteries, and conducted a fuel sample report. No residents were found to be affected by this alleged deficient practice.<br>2. On September 28, 2022, maintenance supervisor contacted GenSet Service, LLC to visit Hoosier Christian Village for a fuel | 09/28/2022 |

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| | performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors.<br><br>Findings include:<br><br>Based on record review on 09/26/22 between 9:15 a.m. and 12:10 p.m. with the Maintenance Supervisor present, there was documentation of an annual generator inspection dated 04/15/22, and a semi annual inspection dated 10/13/21 however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility does have a diesel generator but after having spoken with the facility's generator inspection vendor it was determined that a fuel sample has not been taken by the current vendor.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | sample report. On September 26, 2022, Administrator provided one: one education to maintenance supervisor to inform of requirement of an annual fuel quality test to be performed for diesel powered generator. On September 28, 2022, maintenance supervisor added the task reminder to the TELS program to include a task notification for an annual fuel quality test for diesel-powered generator.<br>3. On September 26, 2022, administrator provided one: one education to maintenance supervisor to inform of requirement of an annual fuel quality test to be performed for diesel powered generator. On September 28, 2022, maintenance supervisor added the task reminder to the TELS program to include a task notification for an annual fuel quality test for diesel-powered generator.<br>4. The maintenance supervisor will bring testing logs to monthly QAPI meetings. Any concerns will immediately be brought to administrator and addressed in QAPI for further review and recommendations. | |
| K 0927<br>SS=E<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br>Gas Equipment - Transfilling Cylinders<br>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, | | | |

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| | Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).<br>11.5.2.2 (NFPA 99)<br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transferring takes place, was provided with properly working mechanical ventilation. This deficient practice could affect at least 20 residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations on 09/26/22 between 12:10 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the oxygen storage/transfer room was equipped with a mechanically vented exhaust fan, however, it was not working at the time of observation. Based on interview at the time of observation, the Maintenance Supervisor agreed the mechanically vented exhaust fan was not working.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | K 0927 | 1. On September 27, 2022, Bode Electric conducted an inspection to the exhaust fan in the oxygen storage room where oxygen transferring takes place. A motor to the fan was repaired.<br>On September 26, 2022, administrator provided one: one education to the maintenance supervisor to conduct routine checks of exhaust fans during weekly environmental rounds, ongoing. No residents were found to be affected by this alleged deficient practice.<br>2. On September 27, 2022, Bode Electric conducted an inspection to the exhaust fan in the oxygen storage room where oxygen transferring takes place. A motor to the fan was repaired.<br>3. Maintenance supervisor will conduct weekly environmental rounds, ongoing, to ensure exhaust fans in all areas are providing properly working mechanical ventilation. Any concerns will be brought to the administrator for immediate action. | 09/27/2022 |

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| | | | 4. Maintenance supervisor will conduct weekly environmental rounds, ongoing, to ensure exhaust fans in all areas are providing properly working mechanical ventilation. Any concerns will be brought to the administrator for immediate action. These audits will be brought to the monthly QAPI meeting for further review and recommendations from the quality assurance team. | |