STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING **01** B. WING _____	R **05/28/2024**

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 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the A Life Safety Code Recertification and State Licensure Survey conducted on 04/16/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/28/24 Facility Number: 000548 Provider Number: 155472 AIM Number: NA At this PSR Life Safety Code survey, Hoosier Village was found in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building and the nurses station near resident Room 127 and Room 128 which was constructed in 2010 were 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 with battery backup installed in all resident sleeping rooms. The facility has a capacity of 24 and had a census of 12 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has no detached	{K 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING **01** B. WING _____	R **05/28/2024**

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{K 000}	Continued From page 1 buildings providing facility services. Quality Review completed on 05/29/24	{K 000}		