STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155401	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEN HUR HEALTH & REHAB	1375 S GRANT AVE CRAWFORDSVILLE, IN 47933

(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	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/12/13 Facility Number: 000461 Provider Number: 155401 AIM Number: 100275290 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Ben Hur Home Health & Rehab 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consisted of one story building additions to a two story facility determined to be of Type V (111) construction with a basement and fully sprinklered. All construction was completed prior to March 3, 2003. The facility has a fire alarm system with	K010000	Submission of this plan of correction shall not constitute or be construed as an admission by Ben Hur Health and Rehab that the allegations contained in this survey report are accurate, or reflect accurately the provision of service to the residents of Ben Hur Health and Rehab.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	smoke detection in the corridors and spaces open to the corridors. All resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 110 and had a census of 81 at the time of this survey. All areas accessible to residents were sprinklered. A detached equipment storage and maintenance building was unsprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/17/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 4 of 28 corridor doors on Wing 1 and the main lounge smoke compartment would close, latch into their door frames, and resist the passage of smoke. This deficient practice affects staff, visitors and 10 or more residents in the main lounge smoke compartment and accessing the main entrance on Wing 1. Findings include: Based on observation with the maintenance director on 09/12/13 between 1:15 p.m. and 3:45 p.m., doors protecting corridor openings to rooms 6 and an an adjacent resident clothing storage room on Wing 1 each failed to	K010018	I. No residents were affected by the lack of doors not latching into the door frames. All of the doors noted in this citation have been repaired/adjusted to close and latch properly. Evidence of doors fitting and closed properly is provided in Attachment #1.II. All other doors protecting corridor openings have been inspected to ensure that they close and latch properly. III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all doors protecting corridor openings close and latch properly, and will ensure all necessary adjustments are made promptly.IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided in Attachment #2. Results of the monitoring will be provided to the Administrator,	09/22/2013

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	latch into their door frames. The storage room and sun room doors had no latches. The door to room 3 hit the door frame, leaving a half inch gap between the top of the door and door frame. The sun room door appeared to have been retro fitted, gapped a half inch along the hinge side, and would pull itself open when closed without a latch to hold it in place. The maintenance director acknowledged at the time of observations, these doors were not working as required. 3.1-19(b)		who will report to the Quality Assurance Committee during quarterly meetings any failure of doors protecting corridor openings to close and latch properly.V. Due to evidence submitted, Ben Hur Health and Rehab is requesting paper compliance of K 0018.	

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to provide an automatic closer for 1 of 1 Wing 10 doors providing access to a combustible materials storage room larger than 50 square feet, a hazardous area. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 17 residents on Wing 10. Findings include: Based on observation with the maintenance director on 09/12/13 at 3:45 p.m., the door separating the sixteen by eight foot storage room on Wing 10 had no self closing device. The room was used for storing paper, plastic and cardboard supplies on shelves and stacked	K010029	I. No residents were affected by the lack of a self closing device on the door of the storage room on Wing 10. A self-closing device has been installed on this door which enables it to close automatically – see evidence provided in Attachment #3.II. All other areas of the facility were evaluated to ensure that no other combustible materials storage rooms are lacking self-closing devices on the door.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all combustible materials storage rooms have self closing devices on the doors, and will ensure all necessary adaptations are made as required.IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided in Attachment #2. Results of the monitoring will be provided to the Administrator, who will report to	09/21/2013

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	on the floor. A rack of clothes was stored in the room. The maintenance director acknowledged at the time of observation, the door needed to self close. 3.1-19(b)		the Quality Assurance committee during quarterly meetings any failure of combustible materials storage areas to have self closing devices on the doors as required.V. Due to evidence submitted, Ben Hur Health and Rehab is requesting paper compliance of K 0029.	

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K010038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exits from Wing 8 were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 15 residents on Wing 8. Findings include: Based on observation with the maintenance director on 09/12/13 at 2:45 p.m., the six foot wide concrete landing serving the exterior exit discharge ramp for Wing 8 was damaged. The concrete surface was worn and pitted, exposing the aggregate across the width of the exit discharge and as much as ten inches wide. The pitting, damage and exposed aggregate made the surface uneven. The maintenance director acknowledged at the time of observation, the surface needed repair.	K010038	I. No residents were affected by the repairs needed to the surface of the discharge ramp from Wing 8. The concrete surface of the ramp has been repaired, providing a smooth, even surface – see evidence provided in Attachment #4.II. All other discharge ramps have been evaluated to ensure that none are in need of repair.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all discharge ramps are in good condition, and will make any necessary repairs when needed.IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided in Attachment #2. Results of the monitoring will be provided to the Administrator, who will report to the Quality Assurance Committee during quarterly meetings any failure of discharge ramps to be maintained in good repair.V. Due to evidence submitted, Ben Hur Health and Rehab is requesting paper compliance of K 038.	09/23/2013

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	3.1-19(b)			

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K010050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all residents, staff and visitors in the event of an emergency. Findings include: Based on review of the facility's Fire Drill Reports and interview with the administrator on 09/12/13 at 12:55 p.m., there was no record of a second shift fire drill for the fourth quarter during 2012. The administrator acknowledged at the time of record review, the fire drill documentation was not there. 3.1-9(b) 3.1-51(c)	K010050	I. No residents were affected by the failure of facility to complete a fire drill on the second shift of the fourth quarter of 2012.II. and III. As fire drills need to be scheduled and conducted quarterly for each shift, a schedule has been developed for the Personnel Director to utilize that fire drills are completed as required – see evidence provided in Attachment #5.IV. The Administrator will verify at least quarterly prior to each Quality Assurance Meeting that fire drills have been conducted on each shift according to the established schedule, and will report to the Quality Assurance Committee any failure to conduct fire drills as required.V. Due to evidence submitted, Ben Hur Health and Rehab is requesting paper compliance of K 050.	09/23/2013

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K010051 SS=F	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 Based on record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system's components and devices such as smoke detectors, heat sensors and fire alarm pull stations was complete. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants.	K010051	We believe that this citation is in error, as apparently the Administrator did not provide all pages of the Fire Alarm Report dated 8/29/13 to the surveyor during review at the time of the survey. The Fire Alarm report of 8/29/13 is provided in Attachment #6, and the total smoke detectors listed on all three pages is 45. The total of only pages 1 and 2 is 38, therefore the surveyor apparently did not have all of the pages listing information on the 45 smoke detectors listed as tested. The facility apologizes for this omission, and respectfully requests that this citation be deleted from the report. Attachment #7 further explains	09/23/2013

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	Findings include: Based on review of the facility's fire alarm system Inspection Reports with the administrator on 09/12/13 at 12:40 p.m., the report for 08/06/12 listed 45 smoke detectors which were tested. The report dated 02/26/13 note 45 smoke detectors of which 16 had been tested. A second fire alarm inspection report dated 08/29/13 documented a functional test for alarm system devices which included 38 smoke detectors. The administrator could not say, at the time of record review why there were such irregular numbers for the smoke detectors even if only a percentage of the devices were checked during two inspections in 2013. She could not identify which, if any devices had not been tested. She immediately called the fire alarm system contractor and reported he would "have to look into it." 3-1.19(b)		the discrepancy of the number of smoke detectors, as a technician was noting a smoke detector to be a heat detector, thus the actual count of smoke detectors in the facility is 44, as confirmed by physicial inspection by the contracted agency on 9/20/13.	

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K010054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to ensure all 45 of 45 smoke detectors had been sensitivity tested. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3.2.1 states, Detector sensitivity shall be checked within one year after installation and every alternative 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 be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity	K010054	I. No residents were affected by the discrepancy in smoke detector sensitivity testing reports. The contracted agency, Superior Systems has provided an explanation in Attachment #7.II. and III. The Administrator will more closely monitor future reports submitted by the contracted agency, to ensure that smoke detector sensitivity testing is conducted and documented appropriately.IV. The Administrator will verify at least quarterly prior to each Quality Assurance Meeting that reports from the contracted agency for fire system maintenance are appropriate, and will report to the quality Assurance Committee any failure of the agency to provide adequate documentation as required.V. Due to evidence submitted, Ben Hur Health and Rehab is requesting paper compliance of K054.ADDENDUM: In Attachment #7, our contracted agency Superior Systems has indicated that in their report of 11/27/12 listing 44 devices, the technicians counted an old heat detector which should not have been on the list, and then also omitted a smoke detector	09/23/2013

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	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. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. 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. Findings include: Based on a review of fire system inspection and test reports with the administrator on 09/12/13 at 12:40 p.m., a Sensitivity Report dated 11/27/12 noted sensitivity testing was performed on 43 smoke detectors. Fire Alarm Inspection and Testing records by the same contractor dated 2/26/13 and 8/6/12 noted there were 45 smoke detectors. A Fire Alarm Inspection and Test report dated 08/29/13 listed 38 smoke detectors		(now labeled #45) which was located in the basement. This smoke detector is labeled #45, because the listing of 11/27/12 included device #3 which was actually a heat detector. So, even though the listing of 11/27/12 showed 44 devices were checked, only 43 of them were actually smoke detectors. Additionally, from this list of 11/27/12, smoke detector #45 located in the basement was omitted. Therefore, the actual count of smoke detectors in the facility, as verified by the contracted agency and our Environmental Services Supervisor during a walk-through on 9/20/13 is 44. During their service call on 9/20/13, the contracted agency tested smoke detector #45 which was inadvertently missed on 11/27/12, and also tested 3 smoke detectors which were replaced in February, 2013. Therefore, all 44 smoke detectors in the facility have been properly tested for sensitivity, and will be re-tested as required on or before November, 2014. Please refer to Attachment #7 which includes 2 pages - one cover letter from Superior Systems verifying the walk-through of 9/20/13 and verification of 44 smoke detectors, and the second page which lists the four smoke detection devices checked for sensitivity during their service call of 9/20/13. Superior Systems has	

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	connected to the fire alarm system had been function tested. The administrator could not say, at the time of record review why there were such irregular numbers for the smoke detectors even if only a percentage of the devices were checked during two inspections in 2013. She could not identify which, if any devices had not been tested. She immediately called the fire alarm system contractor and reported he would "have to look into it." 3.1-19(b)		updated their records to indicate the scheduled testing of 44 smoke devices for sensitivity testing on or before November of 2014. The Administrator will monitor more closely to ensure that all future reports from this contracted agency reflect accurately devices/systems inspected and corrective measures taken.	