

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155683	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2012
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NAME OF PROVIDER OR SUPPLIER B & B CHRISTIAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3208 N SHERMAN DR INDIANAPOLIS, IN 46218
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/07/12</p> <p>Facility Number: 011032 Provider Number: 155683 AIM Number: 200262860</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, B & B Christian Healthcare Center 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.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated</p>	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 43 and had a census of 31 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility services including storage of supplies which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/08/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas for amounts greater than 3000 cubic feet is enclosed within a one hour separation. LSC 8.2.3.2.1 requires doors in fire barriers shall be of an approved type with the appropriate fire protection rating. Further, 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:40 a.m. to 11:35 a.m. on 08/07/12, the oxygen storage and transfilling room contained one liquid oxygen canister and the entry door is not</p>	K0076	An automatic closer was put on the door of the oxygen room.All residents were identified as having the potential to be affected by this deficient practice.Maintenance will check the closer daily to ensure it is functioning properly. Any needed repairs will be reported to and fixed by the Maintenance Supervisor.This will be monitored daily by the Maintenance Supervisor and monthly by the Administrator.Date Completed: August 8, 2012.	08/08/2012	

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	<p>provided with a self closing device. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the oxygen storage and transfilling room is not equipped with a self closing device on the entry door.</p> <p>3.1-19(b)</p>			

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K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure the 1 of 1 liquid oxygen transfilling areas was equipped with a door with a self closing or automatic closing device. LSC 8.2.3.2.1 requires doors in fire barriers shall be of an approved type with the appropriate fire protection rating. Further, 8.2.3.2.1(b) requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of</p>	K0143	An automatic closer was put on the door of the oxygen room.All residents were identified as having the potential to be affected by this deficient practice.Maintenance will check the closer daily to ensure it is functioning properly. Any needed repairs will be reported to and fixed by the Maintenance Supervisor.This will be monitored daily by the Maintenance Supervisor and monthly by the Administrator.Date Completed: August 8, 2012	08/08/2012

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	<p>the facility from 10:40 a.m. to 11:35 a.m. on 08/07/12, the oxygen storage and transfilling room contained one liquid oxygen canister and the transfilling room entry door is not provided with a self closing device on the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the oxygen storage and transfilling room is not equipped with a self closing device on the entry door.</p> <p>3.1-19(b)</p>			

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure documentation for emergency generator monthly load testing for 12 of 12 months included one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of</p>	K0144	<p>A new generator log was put in place on August 8, 2012. The log monitors the generator's monthly load test. A load test was run on August 8, 2012. Load tests will be run monthly thereafter. All residents were identified as having the potential to be affected by this deficient practice. A monthly log on the generator load tests will be maintained. This will be monitored monthly by the Maintenance Supervisor and the Administrator. Date Completed: August 8, 2012</p>	08/08/2012
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	<p>inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Monthly Test Log" documentation with the Maintenance Supervisor during record review from 9:30 a.m. to 10:40 a.m. on 08/07/12, monthly load test documentation for the twelve month period of 09/01/11 through 08/06/12 did not include the duration of each monthly load test, the load percent rating of the Emergency Power Supply (EPS) nameplate rating for each monthly load test or the loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>Based on interview at the time of record review, the Maintenance Supervisor acknowledged monthly load test documentation for the period of September 2011 through August 2012 did not include the duration of each monthly load test, the load percent rating of the Emergency Power Supply (EPS) nameplate rating for each monthly load test or the loading for each monthly load test which maintains the minimum</p>			

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	exhaust gas temperatures as recommended by the manufacturer. 3.1-19(b)			