

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 06/17/2014
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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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K010000	<p>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).</p> <p>Survey Date: 06/17/14</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 smoke detectors in all resident</p>	K010000	Please accept this as my credible allegation of compliance.	
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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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K010015 SS=E	<p>sleeping rooms. The facility has a capacity of 43 and had a census of 29 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-MedicaSurveyor on 06/23/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to provide documentation</p>	K010015	The drywall behind the washer and dryer were repaired.All residents and staff could have	07/10/2014			

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	<p>of the flame spread rating for interior finish materials installed in 1 of over 30 rooms. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, the Laundry which measured 84 square feet in area had a back wall missing a three foot by two foot section of drywall behind the dryers which exposed two wood studs on the Laundry room side of the wall. In addition, a one foot by one foot section of drywall was missing behind the washing machine which exposed one wood stud on the Laundry room side of the wall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged flame spread rating documentation was not available for review for the exposed wood studs in the Laundry.</p> <p>3.1-19(b)</p>		<p>been affected by this deficient practice. The drywall was fixed with fire resistant drywall. This will be monitored by the maintenance supervisor on a weekly basis.</p>		

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K010018 SS=E	<p>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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 2 of over 35 corridor doors were provided with a means suitable for keeping the door closed, latched and would resist the passage of smoke. This deficient practice could affect 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, the following was noted:</p> <p>a. the corridor door to Room 24 is</p>	K010018	The latches on room #24's door and the corridor door to the employee entrance and laundry area door were replaced with self-latching doorknobs. All residents could have been affected by this deficient practice. The doorknobs to both affected areas were replaced with self-latching door knobs. When the doors are shut, they cannot be pushed open without turning the knobs. This will be monitored by the Administrator and maintenance supervisor on a monthly basis.	07/09/2014

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K010025 SS=D	<p>equipped with a positive latching device but the latching mechanism failed to latch the door into the frame.</p> <p>b. the corridor door to the employee entrance and laundry area had the latching mechanism removed. In addition, the door was magnetically locked and could be opened by entering a four digit code. When the fire alarm system was activated at 12:56 p.m., the magnetic holding device released the door so it was not securely latched in the door frame.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor doors would not latch into the door frame and would fail to resist the passage of smoke.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in</p>			

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	<p>accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect three staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, a two inch in diameter hole in the kitchen ceiling above the freezer failed to provide at least a one half hour fire resistance rating for the kitchen ceiling smoke barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned opening in the ceiling did not provide at least a one half hour fire resistance rating for the kitchen ceiling smoke barrier.</p> <p>3.1-19(b)</p>	K010025	The hole in the kitchen ceiling was repaired. The kitchen staff and others could have been affected by this deficient practice. The hole in the kitchen was repaired with fire proof caulking. This will be monitored by the maintenance supervisor on a monthly basis.	07/02/2014

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K010029 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as fuel fired heater rooms are provided with positive latching devices to latch the door into the door frame. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, the laundry measured 84</p>	K010029	The latch on the corridor door to the employee entrance and laundry area was replaced with a self-latching doorknob. All residents could have been affected by this deficient practice. The doorknob to the affected area was replaced with a self-latching door knob. When the door is shut, it cannot be pushed open without turning the knob. A sign has been posted on the interior and exterior of the door reminding employees to turn the doorknob after entering the code. This will be monitored by the Administrator and maintenance supervisor on a monthly basis.	07/09/2014

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	<p>square feet and contained two natural gas fired dryers. The corridor door to the laundry was provided with a self closing device but the latching mechanism for the door handle had been removed. In addition, the door was magnetically locked and could be opened by entering a four digit code. When the fire alarm system was activated at 12:56 p.m., the magnetic holding device released the door so it was not latched. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned hazardous area door was not provided with a positive latching device to latch the door into the door frame.</p> <p>3.1-19(b)</p>						
K010048 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response</p>	K010048	The fire safety plan was revised to include procedures for staff response in the event a battery	06/30/2014			

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	<p>to the activation of battery operated smoke detectors installed in 22 of 22 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Plan" with the Maintenance Supervisor during record review from 9:40 a.m. to 11:45 a.m. on 06/17/14, the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, battery operated smoke detectors are installed in each resident</p>		<p>operated smoke detector is activated. All residents had the potential of being affected by this deficient practice. The fire safety plan was revised to include procedures for staff response in the event a battery operated smoke detector is activated. This will be monitored and reviewed by the Administrator on an annual basis and updated as needed.</p>	

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K010052 SS=E	<p>sleeping room. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to maintain 1 of 6 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could</p>	K010052	The air supply vent deflector was moved to the correct vent. All residents could have been affected by this deficient practice. The air supply vent deflector was moved to the vent that was within three feet of our smoke detector. It deflects airflow away from the smoke detector. This will be monitored by the Administrator and maintenance supervisor on a monthly basis.	07/01/2014			

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K010062 SS=E	<p>affect 24 residents, staff and visitors in the vicinity of Room 15.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, the smoke detector in the corridor outside Room 15 was located on the ceiling within one foot of an air supply vent. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the smoke detector in the corridor outside Room 15 was located on the ceiling within one foot of an air supply vent.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 3 of over 75 sprinklers in the facility which had</p>	K010062	Addendum:Koorsen Fire and Security was called to replace the sprinkler heads on the front entrance canopy. A new policy	08/04/2014

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	<p>become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 24 staff and visitors in the vicinity of the front entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, the front entrance canopy which consisted of combustible wood construction and extended more than four feet from the building was provided with automatic sprinkler protection but each of the three sprinkler heads at this location were entirely covered with gray paint. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned automatic sprinklers were covered with paint.</p> <p>3.1-19(b)</p>		<p>that prohibits the painting over of sprinkler heads has been put in place. All residents, staff, and visitors could have been affected by this deficient practice. The affected sprinkler heads will be removed and replaced by Koorsen Fire and Security. Whenever the facility is painted, the Administrator and Maintenance Supervisor will ensure that no sprinkler heads are painted over.</p>	

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K010068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 fuel fired heater rooms was provided with intake combustion air taken directly from the outside. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 24 residents, staff and visitors in the vicinity of the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, the laundry measured 84 square feet and contained two natural gas fired dryers. It could not be assured the</p>	K010068	The air conditioner in the laundry room was plugged in and turned on. All staff, residents, and visitors could have been affected by this deficient practice. The air conditioner is plugged in and operational and will be running at all times. This will be monitored daily by the maintenance supervisor.	07/01/2014

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K010130 SS=C	<p>laundry was provided with intake combustion air taken directly from the outside. A wall mounted air conditioner was in place near the washing machine and was not in operation. Based on interview at the time of observation, the Maintenance Supervisor stated the air conditioner and two HVAC supply vents are in the laundry but acknowledged the combustion air supply through the air conditioner does not provide air taken directly from the outside when it is not operating.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 22 of 22 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p>	K010130	All of the batteries in all smoke detectors were replaced. All residents had the potential to be affected by this deficient practice. All smoke detectors had their batteries replaced. They will continue to be checked on a monthly basis and the batteries will be replaced as needed. A log has been put in place to monitor the smoke detectors and battery replacement. This will be monitored by the maintenance supervisor and the Administrator on a monthly basis.	06/27/2014

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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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(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
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	<p>Based on review of "Monthly Room Battery Check" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 11:45 a.m. on 06/17/14, documentation of battery operated smoke detector battery replacement within the most recent twelve month period was not available for review for 20 of 22 resident sleeping rooms. The aforementioned maintenance log for resident room battery operated smoke detectors documented battery replacement for Room 6 and Room 10 in October 2013 but stated "N" in response to "Battery Replaced Y/N" for all other resident sleeping rooms for the twelve month period of June 2013 through May 2014. In addition, the maintenance log stated "Batteries Will Be Replaced Every Six Months." Based on observations with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 1:20 p.m. on 06/17/14, battery operated smoke detectors are installed in each of 22 resident sleeping rooms. Manufacturer's specifications affixed to each smoke detector did not state the required frequency of battery replacement. Based on interview at the time of record review and of the observations, the Maintenance Supervisor stated each battery operated smoke detector is supposed to have annual</p>			
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K010154 SS=C	<p>battery replacement but acknowledged the facility was not replacing batteries every six months per the maintenance log requirement for all smoke detectors and acknowledged documentation of battery operated smoke detector battery replacement within the most recent twelve month period was not available for review for 20 of 22 resident sleeping rooms.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in order to protect 29 of 29 residents. LSC 9.7.6.2 requires sprinkler</p>	K010154	The fire watch policy was revised to ensure proper notification of the owner, the insurance carrier, the alarm monitoring company, and other authorities having jurisdiction. All residents had the potential to be affected by this deficient practice. The fire watch policy was revised to ensure proper notification of the owner,	06/30/2014

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	<p>impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Plan: Sprinkler System/Fire Alarm Out of Operation" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 11:45 a.m. on 06/17/14, the fire watch policy did not include notification of the insurance carrier, alarm monitoring company and building owner in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. Based on interview at the time of record review, the Maintenance Supervisor stated no additional fire watch documentation was available for review and acknowledged the written fire watch policy did not include notification of the insurance carrier, alarm monitoring company and building owner in the event the automatic sprinkler system has to be placed out of</p>		<p>the insurance carrier, the alarm monitoring company, and other authorities having jurisdiction. This policy will be monitored and reviewed by the Administrator on an annual basis and updated as needed.</p>				

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	service for four hours or more in a 24 hour period. 3.1-19(b)				