

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<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: 11/20/14</p> <p>Facility Number: 000461 Provider Number: 155401 AIM Number: 100275290</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Ben Hur Home Health and 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.</p> <p>This facility consisted of one story building additions to a two story facility with a basement determined to be of Type V (111) construction and fully sprinklered except a closet cited at K 56. All construction was completed prior to March 3, 2003. The facility has a fire</p>	K010000	Submission of this plan of correction shall not constitute or be construed as an admission by Ben Hur Health and Rehabilitation 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 Rehabilitation.	
---------	---	---------	--	--

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.

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010017 SS=E	<p>alarm system with 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 80 at the time of this survey.</p> <p>All areas accessible to residents were sprinklered. A detached equipment storage and maintenance building was unsprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/26/14.</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 Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor</p>			

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure use areas were separated from the corridors by a partition capable of resisting the passage of smoke in 1 of 10 smoke compartments as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided:</p> <p>(a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect residents, staff and 10 or more residents in the Wing 1 smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 10:45 a.m., the reception office was accessible from the corridor by two sliding glass panels in a three by six foot</p>	K010017	<p>I. No residents were affected by the lack of an electrically supervised automatic detection system in the Reception Office. A contractor has been scheduled to install an electrically supervised automatic detection system in this room.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other areas to ensure there are no other areas in need of electronically supervised automatic smoke detection equipment.</p> <p>III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all areas are properly equipped with required supervised automatic smoke detection equipment.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be provided to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of required smoke detection equipment.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K017.</p>	12/19/2014

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010018 SS=E	<p>opening in the wall. The panels gapped 3/8 inch between the panes when closed. The space was not protected by an electrically supervised automatic detection system. The maintenance director acknowledged at the time of observation, the reception area was not supervised after the close of business hours.</p> <p>3.1-19(b)</p> <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 corridor doors in 3 of 10 smoke compartments would 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, wing 1 and</p>	K010018	I. No residents were affected by the doors noted that were not latching properly. The door protecting the corridor opening to the storage room near the employee lounge, the door to the linen closet between the smoke barrier door between the Wing 1 ramp and the linen closet near Desk 3, and the beauty shop	12/10/2014

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K010020 SS=E	<p>Desk 3 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 between 10:45 a.m. and 1:45 p.m.:</p> <p>a. The doors protecting the corridor opening to the storage room near the employee lounge, the linen closet between the smoke barrier door between the Wing 1 ramp and the linen closet near Desk 3 would not latch into their door frames. The maintenance director acknowledged at the time of observations, these doors were not working as required.</p> <p>b. The door to the beauty shop had a half inch gap near the door knob. The maintenance director said at the time of observation the wood was worn away where someone had repeatedly pried the locked door open without a key.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p>		<p>door have all been repaired/adjusted to close and latch properly.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other doors protecting corridor openings to ensure that they close and latch properly.</p> <p>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.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of doors protecting corridor openings to close and latch properly.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K018.</p>				

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K010021 SS=E	<p>Based on observation and interview, the facility failed to ensure door openings in 1 of 1 second floor stairway access doors was maintained. LSC 8.2.5.2 requires openings through floors such as stairways and vertical conveyors shall be enclosed with fire barrier walls. NFPA 80, the Standard for fire Doors and Fire Windows at 2-1.2, requires fire door assemblies to include latches. NFPA 80, 2-1.4 requires fire doors to be closed and latched at the time of fire. This deficient practice could affect visitor 's staff and 10 or more residents in the Wing 1 smoke compartment adjacent to Wing 3.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 11:10 a.m., the stairway door to the Wing 3 second floor was equipped with a self closer which had been dismantled. The door when opened remained open. The maintenance director said at the time of observation, he did not know the self closer was not working.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only</p>	K010020	<p>I. No residents were affected by the lack of a self closer on the stairway door on Wing 3. The door closure on this door has now been repaired and is functioning properly.II. As all residents have the potential to be affected, all other stairways have been inspected by the Environmental Services Supervisor to ensure all are equipped with self closing devices which function properly.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all stairway doors have self closing devices which function 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. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of stairway doors which do not close and latch properly.V. Due to evidence submitted, facility requests desk review and paper compliance of K020.</p>	12/10/2014			

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure doors to hazardous areas in 2 of 6 smoke compartments, were only held open by devices allowing the door to self-close upon activation of the fire alarm. 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. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice affects visitors, staff and 10 or more residents on Wing 1 and in the main lounge smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 11/20/14 at 12:05 p.m., the self-closing door to Wing 7 soiled utility room failed to latch into</p>	K010021	<p>I. No residents were affected by the lack of properly closing doors on the wing 7 soiled utility room or the soiled utility room by the beauty shop. Both of these doors have now been repaired to ensure they close properly.II. As all residents hve the potential to be affected, all other hazardous areas have been inspected by the Environmental Services Supervisor to ensure that they are equipped with self-closing devices which function properly.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all doors to hazardous areas have self closing devices which function 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. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly</p>	12/10/2014

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K010027 SS=E	<p>the door frame when the upper half of the door hit the latch side of the frame. A three fourths inch gap remained between the door and door frame when the door failed to close. The room was used for the collection of three 45 gallon soiled linen receptacles; each was almost full. The maintenance director said at the time of observation, it appeared the hinge had been damaged.</p> <p>b. Based on observation with the maintenance director on 11/20/14 at 12:45 p.m., the self-closing door to soiled utility room, near the beauty shop failed to latch into the door frame after it was released from opening. The door hit the door frame, preventing it from latching into the door frame. The room stored a full, 40 gallon soiled linen receptacle. The maintenance director said at the time of observation, he didn't know the self closer was not working.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with</p>		meetings any failure of doors to hazardous areas not closing properly.V. Due to evidence submitted, facility requests desk review and paper compliance of K021.				

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010029 SS=E	<p>19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 11 smoke barrier door sets would self close to restrict the passage of smoke. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff, visitors and 10 or more residents in the wing 9 smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 11/20/14 at 2:10 p.m., the smoke barrier doors serving the short 9 smoke compartment failed to close when the fire alarm was tested. The doors were released from the magnets holding them open but gapped six inches when the doors failed to close completely. The maintenance directors agreed at the time of observation, the doors should have closed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾</p>	K010027	<p>I. No residents were affected by the lack of the smoke barrier doors on short 9 hallway closing properly. These doors have now been adjusted to ensure that they close properly and do not gap when the fire alarm is activated.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other smoke barrier doors to ensure that they close properly and do not gap upon activation of the fire alarm.</p> <p>III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all smoke barrier doors close properly, and will ensure all necessary adjustments are made promptly.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of smoke barrier doors not closing properly.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K027.</p>	12/10/2014

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>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 provide automatic closers for doors providing access to 1 of 10 hazardous areas such as a combustible materials storage room larger than 50 square feet. 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 10 or more residents on Wing 10.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 1:55 p.m., the door separating the 150 square foot storage room on Wing 10 had no self closing device. The room was used to store upholstered furniture, linens, spare mattresses and other miscellaneous equipment and materials. The maintenance director said at the time of</p>	K010029	<p>I. No residents were affected by the lack of a self-closing device on the storage room on Wing 10. This door has now been equipped with a self-closing device which functions properly.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other storage rooms to ensure that they have self-closing devices which function properly.</p> <p>III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all storage areas have self-closing devices which function properly, and will ensure all necessary adjustments are made promptly.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of storage areas to have properly</p>	12/10/2014

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010038 SS=E	<p>observation, he didn't know the doors for this storage room was required to self close.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 exits was 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 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff, and 10 or more residents using the Wing 7 sloped exit discharge.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 12:25 p.m., the surface of the sloped concrete exit discharge for Wing 7 had cracked across the width of the walkway, part of the concrete had eroded and been patched. The concrete and patching</p>	K010038	<p>functioning self-closing devices on doors.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K029.</p> <p>I. No residents were affected by the repairs needed to the surface of the discharge ramp from Wing 6 – which we believe was mistakenly noted as the Wing 7 ramp on the survey report. This surface of the ramp has been repaired, providing an even, smooth surface across the width of the exit discharge.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other exit ramps to ensure that they are in good repair with smooth surfaces.</p> <p>III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all exit discharge ramps are in good repair, and will ensure all necessary adjustments are made promptly.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the</p>	12/10/2014

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K010044 SS=E	<p>material continued to deteriorate leaving an uneven surface across the width of the exit discharge. The maintenance director acknowledged the poor condition of the exit discharge at the time of observation, he commented there was a plan to replace the walkway although the work was not yet scheduled.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets was arranged to automatically close and latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects visitors, staff and 10 or more residents in the Wing 10 smoke compartment.</p> <p>Findings include:</p>	K010044	<p>Quality Assurance Committee during quarterly meetings any failure of exit discharge ramps to be in good repair.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K038.</p> <p>I. No residents were affected by the lack of the fire doors by room 79 latching properly when closed. These doors have been adjusted to ensure that they close and latch properly.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other fire door sets to ensure that they all close properly.</p> <p>III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all fire door sets close properly, and will ensure all necessary adjustments are made promptly.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring</p>	12/10/2014			

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010046 SS=E	<p>Based on observation with the maintenance director on 11/20/14 at 1:40 p.m., the fire door set near room 79 was tested twice manually with the maintenance director. One door in the fire door set failed to latch each time the doors were released to close. The door failed to latch again at 2:10 p.m. when the fire alarm was activated. The maintenance director acknowledged at the times of observation, the latching mechanism was not working reliably.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure battery powered emergency light fixtures would operate for exiting from 2 of 10 smoke compartments. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, staff and 10 or more residents on Wing 1 and Wing 7.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14</p>	K010046	<p>will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of fire door sets to close properly.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K044.</p> <p>I. No residents were affected by the failure of the emergency light noted which did not function properly. The light on the Wing 1 corridor and exit discharge from Wing 7 have now been repaired and function properly.II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other emergency lighting to ensure that all are operating properly.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all emergency lighting is functioning properly, and will ensure all necessary adjustments are made promptly.IV. Evidence</p>	12/10/2014

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K010048 SS=C	<p>between 11:45 a.m. and 2:00 p.m., both bulbs in the battery powered emergency light fixtures in the Wing 1 corridor near the main switchboard and installed along the exit discharge from the Wing 7 corridor failed to illuminate when tested twice with the maintenance director. The maintenance director acknowledged at the times of observation, the lights were not working.</p> <p>3.1-19 (b)</p> <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 and interview, the facility failed to provide a written fire plan which included the required procedures for the transmission of the alarm to the fire department for the protection of 80 of 80 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures for the following: (1) Use of alarms (2) Transmission of alarm to the fire department</p>	K010048	<p>of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of emergency lighting to function properly.V. Due to evidence submitted, facility requests desk review and paper compliance of K046.</p> <p>I. No residents were affected by the wording of the facility policy for fire protection, however facility policies have now been revised to indicate that the monitoring company for the facility fire alarm system does automatically notify the fire department when the fire alarm is sounded, unless they have been previously notified that a fire drill is being conducted. (See Attached Revision) II. As all residents have the potential to be affected, facility disaster plans were reviewed and no other issues</p>	12/10/2014			

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>(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 This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director and executive director on 11/20/14 at 10:50 a.m., the written fire plan noted: " once the fire alarm goes off, the Fire System Company is automatically notified by our fire alarm system and will call the facility to find out if the is a drill or a fire. In the event of a fire, the fire department will be notified automatically." The administrator said at the time of record review, the monitoring company does call the facility to verify whether the alarm was for an actual fire. She said the alarm is also transmitted automatically to the fire department. She acknowledged at the time of interview, the written procedure does not reflect the automatic transmission of the fire alarm to the fire department as required.</p> <p>3.1-19(b)</p>		<p>were identified.</p> <p>III. Facility policies are developed and revised by corporate staff to ensure adequacy and uniformity between associated facilities.</p> <p>IV. Facility corporate staff will routinely review and revise facility policies regarding fire protection and disaster preparedness to ensure that all requirements are met.</p> <p>V. . Due to evidence submitted, facility requests desk review and paper compliance of K048.</p>				

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 10 smoke compartments in a one story building of Type V (111) construction. LSC 19.1.6.2 requires one story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 10 or more residents in the Wing 3 and adjacent Wing 1 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 11:05 a.m., sprinkler protection was not</p>	K010056	<p>I. No residents were affected by the lack of sprinkler pipe/head in the unoccupied office on Wing 3 near room 22. A contractor has now installed proper sprinkler protection in this area.II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other areas to determine if additional sprinkler protection equipment was required – none were noted.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all areas have adequate sprinkler protection.IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive</p>	12/10/2014
-----------------	--	---------	---	------------

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 11/20/2014
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K010062 SS=E	<p>provided for the closet in the unoccupied office on Wing 3 near room 22. The maintenance director acknowledged at the time of observation, this enclosure was not protected by a sprinkler.</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</p> <p>1. Based on observation and interview, the facility failed to ensure sprinkler heads protecting 1 of 10 smoke compartments was free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice affects visitors, staff and residents using the Wing 1 access ramp.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 11:55 a.m., a bank of television</p>	K010062	<p>Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of adequate sprinkler protection coverage.V. Due to evidence submitted, facility requests desk review and paper compliance of K056.</p> <p>I. No residents were affected by the condition/location of the sprinkler heads/pipes noted, nor the missing escutcheons. A contractor has made the necessary repairs/replacements/adjustments in the room with television equipment, the closet in the Administrator/Reception office, and the three sprinkler heads under the north exit canopy. Sprinkler heads must be custom made and were ordered by the contractor on 12/11/14 for the sprinkler head in the kitchen dishwashing room, the small dining room near desk 2, in the corridor near the Wing 8 smoke barrier, and under the Wing 9 exit canopy. These will be installed by the contractor as soon as they are obtained, but typically at least three weeks are required to obtain the specially made sprinkler heads needed for these replacements.</p>	12/11/2014	

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>equipment stood within six inches of the only sprinkler protecting the equipment room. The maintenance director acknowledged at the time of observation, the sprinkler head was less than the minimum distance allowed between a sprinkler head and obstruction.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinkler heads protecting occupants in 3 of 6 smoke compartments were free of corrosion, paint and other foreign materials. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 10 or more residents in Wing 7, Wing 8, and Wing 9.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 between 11:00 a.m. and 2:15 p.m.:</p> <p>a. Three sprinkler heads under the north exit canopy were painted white;</p> <p>b. One sprinkler head in the kitchen dishwashing room was coated with a green film, usually evidence of corrosion;</p> <p>c. One sprinkler head in the small dining room near desk 2 was coated with a white spackling material;</p>		<p>Additionally, staff have been Inserviced not to hang any items on sprinkler pipes.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all areas to determine if any sprinkler heads or eschutcheons required repair/replacement/adjustment – none were noted. No other areas were noted to have items hanging from sprinkler pipes.</p> <p>III. The Environmental Services Supervisor will check monthly during building rounds to ensure that items are not hanging on sprinkler pipes, and that all all sprinkler heads and eschutcheons are in good repair, and will ensure all necessary repairs are made promptly.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of sprinkler heads/eschutcheons/pipes to be in good repair and free of hanging items.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K062.</p>	

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>d. One sprinkler head in the corridor near the Wing 8 smoke barrier was coated with paint on one side;</p> <p>e. One sprinkler head under the Wing 9 exit canopy was rusted.</p> <p>The maintenance director acknowledged at the time of observations, the sprinkler heads were not in good condition.</p> <p>3.1-19(b)</p> <p>3. Based on observation, the facility failed to ensure sprinkler heads providing protection for 1 of 10 smoke compartments were maintained. This deficient practice could affect staff, visitors and 10 or more residents on Wing 1.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 between 11:00 a.m. and 11:35 a.m., sprinkler head escutcheons were missing in the storage closet in the administrator's and reception offices. the maintenance director said at the times of observation, he did not know the escutcheons were missing.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview,</p>			

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K010071 SS=E	<p>the facility failed to ensure the piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect visitors, staff and 10 or more residents on Wing 8.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 12:40 p.m., a sprinkler pipe in the clean utility room near room 51 a hanger to support for eight clothes hangers. The maintenance director agreed at the time of observation, sprinkler pipes were not to be used to support other equipment of any kind.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes:</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new</p>						

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>chutes comply with section 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4.</p> <p>(4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry chutes was provided with a self closing 1-hour, fire rated door assembly. LSC 9.5 requires compliance with LSC 8.2. LSC 8.2.3.2.1(b) requires fire doors shall be self closing. This deficient practice could affect visitors, staff, and 10 or more residents the Wing 1 smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 2:15 p.m., a laundry chute opened into the Wing 1 exit corridor. Springs attached to the door failed to self close the door separating the chute from the corridor. The maintenance director acknowledged at the time of observation the chute door did not self close.</p>	K010071	<p>I. No residents were affected by the failure of the laundry chute door to self close. This door and closure have been adjusted to now self-close properly.II. Although all residents have the potential to be affected, there is only one laundry chute in the facility, therefore this is the only door requiring a self-closure to the laundry chute.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that the laundry chute door self-closes 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. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of the laundry chute door</p>	12/10/2014

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010074 SS=E	<p>3-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation, the facility failed to provide privacy curtains in 1 of 58 sprinklered resident rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. This deficient practice affects staff, visitors, and 10 or more residents in the Wing 9 smoke compartment.</p> <p>Findings include: Based on observation with the maintenance director on 11/20/14 at 12:50 p.m., a privacy curtain installed in resident room 74 lacked a 1/2 in. (1.3 cm)</p>	K010074	<p>to self-close properly.V. Due to evidence submitted, facility requests desk review and paper compliance of K071.</p> <p>I. No residents were affected by the privacy curtain in room 74 which had ¼ inch diagonal mesh. This old curtain has been replaced with a new one which meets the proper specifications.</p> <p>II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other privacy curtains in resident rooms to ensure that none have weave on the top panel which does not meet specifications – none were noted.</p> <p>III. The Environmental Services</p>	12/10/2014

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 11/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K010144 SS=F	<p>diagonal mesh or a 70 percent open weave top panel extending 18 in. (46 cm) below the sprinkler deflectors. The maintenance director acknowledged the privacy curtain had 1/4 inch diagonal mesh. 3.1-19(b)</p> <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 observation and interview, the facility failed to ensure 1 of 1 generators serving as the alternate source of power was maintained and capable of automatically connecting to the load within 10 seconds in the event of failure of normal power. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.2.2 requires the emergency system to be arranged so</p>	K010144	<p>Supervisor will check monthly during building rounds to ensure that all privacy curtains meet the required specifications to ensure fire safety/protection.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure privacy curtains to meet the required specifications.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K074.</p> <p>I. No residents were affected by the failure of the emergency generator to operate when tested. An adjustment was made to the gas intake of the emergency generator and it now functions properly and has ignited each time when tested daily on scheduled days of work by the Environmental Services Director since the day of the survey.</p> <p>II. Although all residents have the potential to be affected, there is only one emergency generator utilized by the facility.</p> <p>III. The Environmental Services</p>	11/21/2014

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K010147 SS=E	<p>that, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load after a short delay. NFPA 99, 3-4.2.1(d) requires the generator to start and be on line within 10 seconds. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation on 11/20/14 at 12:00 p.m., the maintenance director attempted to demonstrate the operation of the generator providing emergency power to the facility. Repeated attempts by the maintenance director to start the engine failed. The maintenance director said at the time of observation, he thought the battery might be dead because nothing happened when the ignition was started.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure 3 of 4 Wing 1 attic electrical wiring connections were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c)</p>	K010147	<p>Supervisor will check weekly and monthly as required during building rounds to ensure that the emergency generator starts and functions properly.</p> <p>IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of the emergency generator to start and function properly.</p> <p>V. Due to evidence submitted, facility requests desk review and paper compliance of K144.</p> <p>I. No residents were affected by the lighting not securely attached in the attic above Wing 1, nor the multiplug adapter utilized in the Desk 2 medication room. The lighting has been repaired, and the refrigerators are properly plugged into the receptacle.</p>	12/10/2014			

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 11/20/2014
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect visitors, staff and 10 or more residents in the Wing 1 smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 11:45 a.m., three light bulbs dangled from junction boxes along an electric line in the attic above Wing 1. The uncovered junction boxes exposed the wires within. The maintenance director acknowledged at the time of observation the lighting had not been securely attached to cover the wires in the junction boxes.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a nonfused multiplug adapter was not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This</p>		<p>Additionally, staff have been inserviced on not using multiplug adapters, but rather notifying maintenance when electrical needs are noted.II. As all residents could be affected, the Environmental Services Director inspected all other wiring to ensure accordance with NFPA standards. A thorough search for the inappropriate use of multiplug adapters was conducted, and none were found.III. The Environmental Services Supervisor will check monthly during building rounds to ensure that all wiring is in accordance with NFPA standards to ensure fire safety/protection.IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided. Results of the monitoring will be reported to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of electrical wiring to meet NFPA standards.V. Due to evidence submitted, facility requests desk review and paper compliance of K147.</p>		

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 11/20/2014	
NAME OF PROVIDER OR SUPPLIER BEN HUR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>deficient practice could affect staff, visitors and 10 or more residents in the main lounge smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 11/20/14 at 12:05 p.m., two refrigerators in the Desk 2 medicine room used a multiplug adapter to supply power. The maintenance director said at the time of observation, he was not aware the adapter was in use.</p> <p>3.1-19(b)</p>						