

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155683	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2015
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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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K 0000 Bldg. 01	<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: 08/18/15</p> <p>Facility Number: 011032 Provider Number: 155683 AIM Number: 200262860</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 sleeping rooms. The facility has a capacity of 43 and had a census of 26 at</p>	K 0000	Please accept this 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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K 0018 SS=E Bldg. 01	<p>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>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 1 of 22 resident room doors protecting corridor openings would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors in the vicinity of Room 13.</p> <p>Findings include:</p>	K 0018	The door in question was repaired to prevent smoke from passing through the doorway. It was then treated with a no-burn fire retardant. All residents had the potential of being affected by this deficient condition. All other doors in the building were checked. There were no others found to have this deficient condition. The Administrator created a worksheet that will be	09/16/2015

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K 0025 SS=F Bldg. 01	<p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:20 a.m. to 11:30 a.m. on 08/18/15, a one inch gap between the top of the corridor door to Room 13 and the door jamb on the latching side of the door was noted when the door was closed and latched. The floor in the corridor outside Room 13 shifted due to settling which caused the door frame to shift and not properly align in the door jamb and would fail to resist the passage of smoke when fully closed and latched. Based on interview at the time of observation, the Maintenance Supervisor stated the floor settling in the corridor outside Room 13 caused the door frame to shift and acknowledged the one inch gap between the top of the corridor door to Room 13 and the door jamb would fail to resist the passage of smoke when fully closed and latched.</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 accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired</p>		<p>kept at the nurse's station. All employees will be able to report environmental problems on this worksheet. An informative inservice, explaining the process of how the worksheet is to be used, was given by the Administrator to all staff. This worksheet will be monitored daily, for new reports of environmental problems, by maintenance and monthly by the Administrator. This will be an ongoing process.</p>	

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	<p>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 all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 10:20 a.m. to 11:30 a.m. on 08/18/15, a one foot wide by three foot wide piece of wood paneling was used to partially cover up a hole in the ceiling of the main electrical room which failed to provide at least a one half hour fire resistance rating for the ceiling smoke barrier. In addition, a six inch in diameter hole in the ceiling by the wood paneling for the passage of five cables was noted in the ceiling of the main electrical room which exposed the attic above. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned wood paneling and opening in the ceiling for the passage of cables did not provide at</p>	K 0025	<p>The ceiling in question was repaired with fire retardant drywall. All residents had the potential of being affected by this deficient condition. After the building was inspected, no other areas were found to have this deficient condition. The Administrator created a worksheet where he and the Maintenance Supervisor will do a monthly walkthrough of the facility to check for needed environmental repairs. Any areas requiring repair will be noted on this worksheet and will be repaired by the maintenance staff as soon as possible. This worksheet and the subsequent needed repairs will be monitored monthly by the Administrator and the Maintenance Supervisor on an ongoing basis.</p>	09/16/2015

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K 0050 SS=C Bldg. 01	<p>least a one half hour fire resistance rating for the main electrical room ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Supervisor during record review from</p>	K 0050	The fire drill book was updated for the nightshift to make the drill times more random. All residents could have been affected by this deficient practice. None were found to be affected. The Administrator worked with the Maintenance Supervisor to work out more random times for all future fire drills. The fire drill book will be monitored quarterly by the Administrator to ensure that all fire drill times are being done on a more random basis. This will be an ongoing process.	09/16/2015

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	<p>9:10 a.m. to 10:20 a.m. on 08/18/15, third shift fire drills conducted on 09/17/14, 03/10/15, and 06/17/15 were conducted at, respectively, 2:30 a.m., 2:00 a.m. and 3:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>			