

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/29/2016
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NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W SR 46 ELLETTSVILLE, IN 47429
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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: 06/29/16</p> <p>Facility Number: 000558 Provider Number: 155523 AIM Number: 100267550</p> <p>At this Life Safety Code survey, Richland Bean Blossom Health Care 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 (000) construction and was 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</p>	K 0000	<p>This plan of correction constitutes Richland Bean Blossom Health Center's written allegation of compliance for the deficiencies cited on the Life Safety Code survey. Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet state and federal requirements. Richland Bean Blossom Health Center respectfully requests consideration of this Plan of Correction for paper compliance. Plan of Compliance date: 07/29/2016</p>	
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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 0025 SS=E Bldg. 01	<p>capacity of 79 and had a census of 69 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for one detached smoking shed. The facility has three detached buildings providing facility storage services which were not sprinklered.</p> <p>Quality Review completed on 07/05/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was protected to maintain at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 24 residents, staff</p>	K 0025	<ol style="list-style-type: none"> Holes noted at the Main Mechanical Room, closet 208, room 308 and annular space will be filled with fire caulk. The missing escutcheon will be replaced. All residents have the potential to be affected. An inspection of egress through all fire walls will be conducted and any breach corrected. Any service work involving fire walls will be inspected upon the completion of any work near or around any fire wall. Results will be discussed monthly in the Quality 	07/29/2016

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	<p>and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, the following was noted:</p> <p>a. two separate one inch in diameter holes for the passage of three cables were noted in the ceiling of the Main Mechanical Room and were not filled with a material capable of maintaining the smoke resistance of the smoke barrier.</p> <p>b. a two inch in diameter hole was noted in the closet for Room 208 where the sprinkler location had a missing escutcheon.</p> <p>c. the one inch annular space surrounding the escutcheon for the sprinkler location in the closet for Room 308 was not filled with a material capable of maintaining the smoke resistance of the smoke barrier.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned openings in the ceiling smoke barrier were not filled with a material capable of maintaining the smoke resistance of the ceiling smoke barrier.</p> <p>3.1-19(b)</p>		<p>Assurance meeting. July 29, 2016</p>	

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 6 hazardous areas such as fuel fired heater rooms were separated from other areas by smoke resistant partitions. This deficient practice could affect 24 staff and visitors in the vicinity of the Laundry Room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, the following was noted: a. two separate one inch in diameter holes for the passage of three cables were noted in the ceiling of the Main Mechanical Room which contained a natural gas fired</p>	K 0029	<ol style="list-style-type: none"> The two holes in the Main Mechanical Room will be filled with fire caulk. The missing section of ceiling tile will be replaced. All residents have the potential to be affected. All cabling in the building going into the ceiling will be observed for proper passage. Ceilings will be inspected for integrity and eliminate any holes found. Any cable service work related to ceiling cabling will be inspected upon completion of future servicing. Results will be discussed monthly in the Quality Assurance meeting. July 29, 2016 	07/29/2016

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K 0048 SS=C Bldg. 01	<p>furnace. In addition, a two inch in diameter hole was also noted in the south wall of the Main Mechanical Room near the ceiling for the passage of two cables.</p> <p>b. a four inch by four inch section of ceiling tile was missing by the sprinkler location behind the natural gas fired dryers in the Laundry.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned holes in the Main Mechanical Room and the Laundry did not separate these hazardous areas from other spaces by smoke resistant partitions.</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 document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms</p>	K 0048	<p>1. The Safety, Fire and Disaster Policy will be revised to accurately reflect the plan.</p> <p>2. All residents, visitors, and staff have the potential to be affected. The Policy will be updated to accurately reflect the plan.</p> <p>3. Revision of the plan will ensure the practice does not recur.</p> <p>4. The plan will be reviewed and approved at Quality Assurance meeting on an annual basis.</p>	07/29/2016			

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	<p>(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 affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Safety, Fire & Disaster Policy" documentation with the Maintenance Director during record review from 9:25 a.m. to 11:00 a.m. on 06/29/16, the written fire safety plan for the facility was incomplete as a referenced policy within the written fire safety plan was not available for review. Standard 16 on page 7 of the written fire safety plan states "Fire protection equipment and features are provided and maintained in accordance with NFPA and State regulations (see Environmental Services and Safety Policy)." An "Environmental Services and Safety Policy" could not be located and was unavailable for review. Based on interview at the time of record review and during the exit conference at 2:30 p.m., the Maintenance Director and the Administrator acknowledged the referenced "Environmental Services and</p>		July 29, 2016				

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K 0050 SS=F Bldg. 01	<p>Safety Policy" for the facility could not be located and was unavailable for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 1 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 Direct Supply TELS Logbook Documentation "Fire Drills" documentation with the Maintenance Director during record review from 9:25 a.m. to 11:00 a.m. on 06/29/16, documentation of a fire drill conducted</p>	K 0050	<p>1. Paper documentation of the fire drill, response, and signatures of those staff present will be kept as well as scanned to the TELS system.</p> <p>2. All residents have the potential to be affected. All monthly fire drills will have signature pages as backup to those scanned in the TELS system.</p> <p>3. The fire drill documentation sheets will be scanned to the TELS system the same day after the drill has been conducted.</p> <p>4. Proof of documentation will be reviewed at the monthly Quality Assurance meeting. July 29, 2016</p>	07/29/2016			

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	<p>on the second shift in the second quarter (April, May, June) 2016 was not available for review. In addition, documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) 2015 was also not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a fire drill conducted on the second shift in the second quarter (April, May, June) 2015 and 2016 was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to document staff participation for all fire drills conducted on the first, second and third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Direct Supply TELS Logbook Documentation "Fire Drills" documentation with the Maintenance Director during record review from 9:25 a.m. to 11:00 a.m. on 06/29/16, documentation for first, second and third shift fire drills conducted in the most recent twelve month period did not</p>						

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K 0062 SS=F Bldg. 01	<p>include staff who participated in the fire drill. Based on interview at the time of record review, the Maintenance Director stated staff who participated in a fire drill sign a sheet which is scanned and uploaded into TELS, the scanned sheet could not be located in TELS at the time of the survey and acknowledged documentation of staff participation for all fire drills conducted on the first, second and third shift in the most recent twelve month period was not available for review.</p> <p>3.1-19(b) 3.1-51(c)</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 record review, observation and interview; it could not be assured 1 of 1 sprinkler systems was inspected quarterly for 1 of 4 calendar quarters and was kept in reliable operating condition. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained</p>	K 0062	<p>1. Documentation of quarterly sprinkler inspections will be available for review and immediate repair of any failed devices by Koorsen's. A copy of the documentation for sprinkler inspection and any repair(s) will be provided to the facility. Facility will</p>	07/29/2016	

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	<p>in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:25 a.m. to 11:00 a.m. on 06/29/16, documentation of quarterly sprinkler inspection in the second quarter (April, May, June) of 2016 was not available for review. Review of Koorsen Fire & Security's one page "Detection Inspection Report" dated 04/19/16 only listed three devices in the inspection report and stated "Fail" as the result of testing the three devices listed as "PIV/Supervisory", "Water Flow at riser" and "Other at riser." In addition, it could not be assured Koorsen's 04/19/16 inspection report represented the second quarter 2016 sprinkler system inspection report. Based on observation with the Maintenance Director during a tour of the</p>		<p>ensure the single fire hydrant on facility property is inspected, however, facility was notified the hydrant is the property of the city. (see uploaded document Attachment A). Escutcheon in the closet of room 208 will be put into place. The lint will be removed on the sprinkler located behind the dryers in the laundry.</p> <p>2 This practice could affect all visitors, staff, and residents. Visual observation of all sprinkler heads will be conducted to ensure escutcheons are present and heads are dust-free. Upon quarterly sprinkler inspections, facility will ensure all devices are inspected before signing off on the inspection.</p> <p>3. Rounding monthly and utilizing direct observation will be done and any dust removed and escutcheons placed if missing.</p> <p>4. Results will be discussed monthly in the Quality Assurance meeting.</p> <p>July 29, 2016</p>	

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	<p>facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, Koorsen Fire & Security had affixed a hanging tag at the sprinkler system riser dated 04/20/16 which stated "NA" to "Alarms operated?" Based on interview at the time of record review and of observation, the Maintenance Director stated the PIV was in operating condition and contacted Koorsen to fax quarterly sprinkler system documentation to the facility which was not received at the time of the survey and acknowledged it could not be assured 1 of 1 sprinkler systems was inspected quarterly for 1 of 4 calendar quarters and was kept in reliable operating condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff</p>			

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	<p>and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:25 a.m. to 11:00 a.m. on 06/29/16, documentation of facility fire hydrant inspection within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has one fire hydrant on the premises and acknowledged documentation of facility owned fire hydrant inspection within the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, one fire hydrant was noted on the south side of the premises near the rear parking lot.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient</p>			

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	<p>practice could affect 20 residents, staff and visitors in the vicinity of Room 208.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, the pendent sprinkler in the closet for Room 208 had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned automatic sprinkler location had a missing escutcheon.</p> <p>3.1-19(b)</p> <p>4. Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers which had 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 two staff and visitors in the Laundry.</p>			

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K 0064 SS=D Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, the pendent sprinkler installed behind the dryers in the Laundry was covered with lint. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler location had foreign materials attached to it.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 10 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give</p>	K 0064	<p>1. Facility will ensure all portable fire extinguishers are inspected yearly. Placard will be obtained for the K class extinguisher in the kitchen and placed on the extinguisher itself. 2. Residents and staff observing residents have the potential to be affected. Monthly inspections will occur for proper operation and documentation to ensure the fire extinguisher inspection has been completed. 3. The placard will be permanently placed on the K</p>	07/29/2016

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	<p>maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect four residents, staff and visitors in the smoking shed.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, the inspection tag affixed to the portable fire extinguisher in the smoking shed which has resident access indicated January 2013 as the date the most recent annual maintenance was performed. Based on interview at the time of observation, the Maintenance Director stated no other annual fire extinguisher maintenance documentation for the smoking shed fire extinguisher was available for review and acknowledged the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve month period.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to document inspection of 1 of 10 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers,</p>		<p>class extinguisher. 4. All portable extinguishers will be inspected monthly and/or after any use. Results will be discussed monthly in the Quality Assurance meeting. July 29, 2016</p>		

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	<p>Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect four residents, staff and visitors in the smoking shed.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, the inspection tag affixed to the portable fire extinguisher in the smoking shed which has resident access indicated November 2013 as the most recent monthly inspection. Based on interview at the time of observation, the Maintenance Director stated no other monthly fire extinguisher inspection documentation for the smoking shed fire extinguisher was available for review and acknowledged a monthly inspection for the aforementioned portable fire</p>						

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	<p>extinguisher was not documented for the most recent twelve month period.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect four staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the</p>			

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K 0069 SS=D Bldg. 01	<p>Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, a portable K Class fire extinguisher was located in the kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Director acknowledged a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999</p>	K 0069	<p>1. Maintenance will ensure each semiannual hood and exhaust inspection is performed and documentation received.</p> <p>2. No residents have the potential to be affected, however kitchen staff in the kitchen have the potential to be affected.</p>	07/29/2016

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	<p>edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect four staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:25 a.m. to 11:00 a.m. on 06/29/16, documentation of semiannual hood extinguishing systems inspection for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of semiannual hood extinguishing systems inspection for the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and</p>		<p>Maintenance will be responsible to obtain proper documentation following each inspection.</p> <p>3. Maintenance will contact the company doing the inspection within one week of inspections if results of such inspection have not been received.</p> <p>4. Maintenance will report on any inspections at the monthly Quality Assurance meeting.</p> <p>July 29, 2016</p>	

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	<p>certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect four staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:25 a.m. to 11:00 a.m. on 06/29/16, documentation of semiannual kitchen exhaust systems inspection within the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on</p>			

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K 0076 SS=E Bldg. 01	<p>06/29/16, a sticker affixed to the kitchen range hood indicated the most recent hood inspection was performed by Koorsen Environmental Services in 02/01/16. No other kitchen exhaust systems inspection documentation prior to 02/01/16 was available for review. Based on interview at the time of record review and of the observation, the Maintenance Director acknowledged documentation of semiannual kitchen exhaust systems inspection six months prior to 02/01/16 was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 4 of 6 cylinders of</p>	K 0076	1. The E cylinders were removed and placed in the proper area and	07/29/2016			

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	<p>nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart in the fourth floor Lab. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the Station A nurse's station.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, four of six 'E' type oxygen cylinder were laying on the floor of the Station A nurse's station Nursing Storage Room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged each of four 'E' type oxygen cylinders in the aforementioned storage room were not properly chained or supported in a proper cylinder stand or cart.</p> <p>3.1-19(b)</p>		<p>secured.</p> <p>2. Residents on part of 100 hall and 200 hall have the potential to be affected. Maintenance Director will ensure all oxygen cylinders are properly secured.</p> <p>3. Rounds will be conducted to ensure E cylinders are stored and secured properly. Any concerns will be corrected immediately.</p> <p>4. Findings will be reviewed at the monthly Quality Assurance meeting. July 29, 2016</p>	

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K 0130 SS=F Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 40 of 40 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> <p>Based on record review with the Maintenance Director from 9:25 a.m. to 11:00 a.m. on 06/29/16, an itemized list of monthly resident sleeping room battery operated smoke detector testing and annual cleaning was not available for review for the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director stated monthly testing and annual cleaning is listed as a task to complete in Direct Supply TELS Logbook Documentation but acknowledged an itemized list of testing and cleaning for each resident sleeping room location was not available for review. Based on observations with the Maintenance</p>	K 0130	<ol style="list-style-type: none"> 1. Expired smoke detector in Room 402 will be replaced. An itemized list of monthly resident room battery smoke detector testing and cleaning will be done and documented. Smoke detectors will be replaced no more than ten years of manufacture date. 2. All residents have the potential to be affected. An itemized listing of monthly cleaning and testing will be conducted. 3. Development of an individual battery operated smoke detector checklist will be utilized monthly. 4. Maintenance will keep an electronic log of these inspections and monitor monthly. Findings will be reviewed at the monthly Quality Assurance meeting. July 29, 2016 	07/29/2016

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K 0144 SS=F Bldg. 01	<p>Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, Kidde Model 0916 battery operated smoke detectors are installed in resident sleeping rooms 401 through 408. Kidde Model i9010 battery operated smoke detectors are installed in all other resident sleeping rooms. Manufacturer's information affixed to each resident sleeping room smoke detector in the facility stated to test monthly, clean annually and replace the detector ten years after the manufacture date. The manufacture date listed on the battery operated smoke detector in Room 402 was listed as 2004. Based on interview at the time of the observations, the Maintenance Director acknowledged the manufacture date listed on the battery operated smoke detector in Room 402 was listed as 2004 and should have been replaced after 2014.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.</p>						

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	<p>3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 3 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly</p>	K 0144	<p>1. Maintenance will place the emergency generator under 30 minute load test monthly using proper methods.</p> <p>2. All residents, staff, and visitors have the potential to be affected by this practice. Load tests will be conducted monthly and logged accordingly.</p> <p>3. TELS will be utilized monthly to record the Emergency Power Generator load test.</p> <p>4. Monthly review by the Maintenance Director will ensure this deficient practice will not recur and findings reviewed at the monthly Quality Assurance meeting. July 29, 2016</p>	07/29/2016
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	<p>maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator" documentation with the Maintenance Director during record review from 9:25 a.m. to 11:00 a.m. on 06/29/16, documentation of monthly load testing for November 2015, February 2016 and April 2016 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of monthly load testing for the aforementioned three months was not available for review.</p> <p>3.1-19(b)</p>						
K 0147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring.</p>	K 0147	<p>1. Power strips in the Clinical Liaison office and room 203 have been removed. Extension cords or power strips will not be used as a substitute for fixed wiring. 2.</p>	07/29/2016			

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	<p>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. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 20 residents, staff and visitors in the vicinity of Room 203.</p> <p>Findings include:</p>		<p>No residents, staff, or visitors were affected by this deficient practice. 3. Rounding of the building will be conducted by Maintenance to ensure no power strips are being used inappropriately. 4. Findings will be reported at the monthly Quality Assurance meeting. July 29, 2016</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/29/2016
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NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W SR 46 ELLETTSVILLE, IN 47429
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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
	<p>Based on observations with the Maintenance Director during a tour of the facility from 11:00 a.m. to 1:50 p.m. on 06/29/16, the following was noted:</p> <p>a. a telephone charger was plugged into a power strip on the floor underneath the resident bed nearest the corridor door in Room 203.</p> <p>b. a microwave oven and a refrigerator were plugged into a power strip in the Community Liaison Director's office.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring in the patient care vicinity in Room 203 and in the Community Liaison Director's office.</p> <p>3.1-19(b)</p>			