

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155683	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/25/2013
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NAME OF PROVIDER OR SUPPLIER  B & B CHRISTIAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3208 N SHERMAN DR INDIANAPOLIS, IN 46218
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/25/13</p> <p>Facility Number: 011032 Provider Number: 155683 AIM Number: 200262860</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, B &amp; 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</p>	K010000	Please accept this as our credible allegation of compliance.	

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

TITLE

(X6) DATE

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

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	<p>rooms. The facility has a capacity of 43 and had a census of 31 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/30/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of over 40 corridor doors was provided with a means suitable for keeping the door closed. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 10:45 a.m. to 12:10 p.m. on 09/25/13, the linen closet corridor door by the Nurses' Station did not have a latch which prevented the door from latching into the door frame. The aforementioned corridor door did have a door handle but the latching mechanism had been removed. Based on interview at</p>	K010018	The latch on the linen closet was replaced. Other residents and visitors had the potential of being affected by this deficient practice. A monitoring system has been put in place to ensure that all doors operate properly. The Maintenance Supervisor will check all doors bi-weekly. A monitoring log has been put in place. The Maintenance Supervisor will check and sign the log bi-weekly. The Administrator will check it monthly.	09/26/2013			

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	<p>the time of observation, the Maintenance Supervisor acknowledged the aforementioned corridor door latching mechanism had been removed.</p> <p>3.1-19(b)</p>			

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K010025 SS=F	<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 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 openings through 2 of 4 smoke barrier walls were protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during the tour of the facility from 10:45 a.m. to 12:10 p.m. on 09/25/13, the following was noted:</p> <p>a. the two inch annular space surrounding two, one inch in diameter pipes passing through the smoke barrier wall above the south corridor smoke barrier door set by the Administrator's Office was not smoke resistant.</p> <p>b. the two inch annular space surrounding one of two, one inch in diameter pipes</p>	K010025	All pipes were sealed with fire resistant caulk. All residents had the potential of being affected by this deficient practice. The pipes will be checked bi-weekly by the Maintenance Supervisor. A log has been put in place for monitoring the checking of the pipes. The Maintenance Supervisor will check the pipes bi-weekly and a log will be kept. The Administrator will check pipes and the log monthly.	09/27/2013	

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	<p>passing through the smoke barrier wall above the north corridor smoke barrier door set by the oxygen storage and transfilling room was not smoke resistant. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned openings in the smoke barrier wall above the south and the north smoke barrier corridor door sets failed to maintain the smoke resistance of each smoke barrier.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as soiled linen rooms is provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during the tour of the facility from 10:45 a.m. to 12:10 p.m. on 09/25/13, the soiled linen room by the Nutrition Pantry has two corridor doors and the east door to the room was not provided with a self closing device to close and latch the door into the door frame. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned soiled</p>	K010029	A self closing hinge has been placed on the soiled utility room door. All residents had the potential of being affected by this deficient practice. The door will be inspected monthly to ensure that it is working properly. The door will be inspected monthly by the Maintenance Supervisor. A log will be maintained by the Maintenance Supervisor and checked monthly by the Administrator.	09/30/2013	

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	linen room corridor door was not provided with a self closing device to close and latch the door into the door frame.  3.1-19(b)			

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K010069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 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, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the vicinity of the kitchen. This deficient practice could affect two staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of SimplexGrinnell "Range Hood Systems Report" documentation dated 09/05/12 and 03/07/13 with the Maintenance Supervisor during record review from 9:10 a.m. to 10:45 a.m. on 09/25/13, documentation of a semiannual kitchen hood extinguishing system service record after 03/07/13 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the SimplexGrinnell repair technician who schedules and performs semiannual inspections no</p>	K010069	The range hood was inspected by Simplex Grinnell on September 27, 2013. They were running behind schedule. All residents had the potential of being affected by this deficient practice. The Administrator will keep the next scheduled inspection date in his computer. Simplex Grinnell will be called and reminded two weeks prior to future inspection dates. This will be monitored by the Maintenance Supervisor and Administrator every six months.	09/27/2013	

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	<p>longer works for SimplexGrinnell and acknowledged it has been more than six months since the most recent semiannual kitchen exhaust system inspection was performed on 03/07/13.</p> <p>3.1-19(b)</p>			

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K010144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the reliable source documentation for the off site fuel source for 1 of 1 emergency generators was signed by a person with the technical expertise to make the reliable source claim. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> <li>a) Liquid Petroleum products at atmospheric pressure</li> <li>b) Liquefied petroleum gas (liquid or vapor withdrawal)</li> <li>c) Natural or synthetic gas</li> </ul> <p>Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary</p>	K010144	A letter was obtained from the gas company. All residents had the potential of being affected by this deficient practice. The letter will be kept and maintained in the contract book. The Administrator will maintain a copy of the letter and have it updated as needed.	09/30/2013

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	<p>energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following:</p> <ol style="list-style-type: none"> <li>1. A statement of reasonable reliability of the natural gas delivery.</li> <li>2. A brief description that supports the statement regarding the reliability.</li> <li>3. A statement that there is a low probability of interruption of the natural gas.</li> <li>4. A brief description that supports the statement regarding the low probability of interruption,</li> <li>5. The signature of a technical person from the natural gas provider.</li> </ol> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Citizens Energy Group natural gas supplier letter dated 05/29/09 with the Maintenance Supervisor during record review from 9:10 a.m. to 10:45 a.m. on 09/25/13, the natural gas provider letter was signed by the "Commercial Sales Consultant."</p> <p>Based on interview at the time of record review, the Maintenance Supervisor stated the fuel source for the emergency generator was natural gas and</p>				

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	acknowledged the natural gas provider letter was not signed by a person with the technical expertise to make the reliable source claim.  3.1-19(b)			