

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 05/20/2014
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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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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: 05/20/14</p> <p>Facility Number: 000558 Provider Number: 155523 AIM Number: 100267550</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</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 hardwired smoke detection in the corridors and in spaces open to the corridors. All resident rooms</p>	K010000		

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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K010046 SS=E	<p>were equipped with battery powered smoke detectors. The facility has a capacity of 79 residents and had a census of 69 at the time of this survey.</p> <p>All areas where residents had customary access were sprinklered except the detached smoke hut. All areas providing facility services with the exception of three detached general storage buildings were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/27/14.</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 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 the exterior exit discharge paths for 2 of 7 emergency exits were provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided</p>	K010046	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an	06/04/2014			

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	<p>for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 20 or more residents using the main dining room and business hall exit discharges to the public way.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/20/14 at 12:40 p.m., the exit discharge paths from the east business hall emergency exit and the south dining room emergency exit were not provided with the emergency lighting. The maintenance director confirmed at the time of observation, the lighting provided outside these exit discharges was not connected to the emergency generator and would not be illuminated in the event of a power outage.</p> <p>3.1-19(b)</p>		<p>admission or agreement by Richland Bean Blossom Health Care Center of the facts alleged or conclusions set forth in this statement</p> <p>of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>Please accept this plan of correction as our credible allegation of compliance with all regulatory requirements.</p> <p>K 046</p> <p>The facility will provide and maintain proper emergency powered egress lighting for means of egress.</p>				

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			<p>The facility installed and connected the emergency egress lighting to the generator emergency power for the East business hall emergency exit and the South dining room emergency exit doors on 6/4/14.</p> <p>No other doors providing emergency powered egress lighting were found to be affected thus removing the potential for others to be affected.</p> <p>Preventive Maintenance Life Safety rounds will continue to include observation of proper emergency egress lighting .</p> <p>Monitoring will be preformed weekly times 1 month and then monthly as per facility's Preventive Maintenance Life Safety Code rounding protocol and document on the Monthly Maintenance Checks rounding form , results will be reviewed monthly by the Administrator and the Quality Assurance Committee.</p> <p>Plan of Correction date: 06/04/14</p>	

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K010051 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure 16 of 35 smoke detectors were sensitivity tested. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If</p>	K010051	<p>K 051</p> <p>The facility does strive to provide and maintain a system that has effective warning devices for fire.</p> <p>The facility has replaced the mentioned smoke detectors on 5/23/14 and all smoke detectors have been tested for sensitivity on 5/28/14 with passing results thus</p>	05/28/2014
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	<p>the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p> <p>Findings include:</p>		<p>satisfying NFPA 72, 7-3.2.1</p> <p>All other areas of the facility were properly protected thus no further areas were affected.</p> <p>Preventative Maintenance Life Safety record reviews will continue to include proper maintaining of testable smoke detectors and timely sensitivity testing within one year of installation and every alternate year thereafter per state/federal regulations.</p> <p>Monitoring will be performed monthly as per Preventative Maintenance Life Safety record reviews to ensure timeliness of testing procedures and the results reported to the Administrator and the Quality Assurance Committee.</p> <p>Plan of Correction date: 5/28/14</p>				

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K010062 SS=E	<p>Based on a review of the Sensitivity and Detection Inspection Report of 01/31/13 on 5/20/14 at 3:40 p.m. with the maintenance director and administrator, smoke detector sensitivity test records for 16 smoke detectors were incomplete. The sensitivity record noted, "did not test" for 16 smoke detectors. There was no record of why the test had not been done. The maintenance director said at the time of record review, he did not know why the detectors had not all been tested and produced a 01/30/14 record as evidence of a more current sensitivity test. This was in fact, a function test of all the devices. The maintenance director immediately and repeatedly called the contractor for additional information. He reported the smoke detectors which had not been sensitivity tested were outdated and sensitivity testing had not been done. The maintenance director said he had not been informed of the problem, had requested documentation of the claim and the contractor could provide none.</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,</p>						

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	<p>NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 3 smoke compartments were free of corrosion and foreign materials such as grime. NFPA 25, 2-2.1.1 requires sprinklers to be free of foreign materials and corrosion. This deficient practice affects staff, visitors and 20 or more residents in 400 hall and main dining room smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/20/14 between 12:10 p.m. and 2:45 p.m., the following sprinkler heads were corroded or had evidence of foreign materials:</p> <ul style="list-style-type: none"> a. One sprinkler head in the single shower was turning green, usually evidence of corrosion; b. Two sprinkler heads in the medical records office storage room had paint on them; c. Six sprinkler heads in the laundry were coated with a gray fuzzy material; d. Two sprinkler heads in the kitchen appeared to be rusting and coated with a gray fuzzy grime. <p>The maintenance director acknowledged at the time of observations, the condition and foreign materials coating the sprinkler heads could affect their</p>	K010062	<p>K 062</p> <p>The facility does strive to ensure that automatic sprinkler systems are continuously maintained in reliable operating condition.</p> <p>The facility will ensure that the sprinkler heads are maintain in reliable opertaing conditions. The following mentioned sprinkler heads will be replaced and/or made free from any foreign materials or corrosion by 6/11/14.</p> <ul style="list-style-type: none"> a. 1 sprinkler head in the single shower room replaced b. 2 sprinkler heads in the medical records office storage room paint removed c. 6 sprinkler heads in the laundry freed for debris d. 2 sprinkler heads in the kitchen replaced <p>All other sprinkler head s were properly maintained are present thus no other areas are affected</p>	06/11/2014

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K010076 SS=D	<p>function.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the</p>	K010076	<p>Preventative Maintenance Life Safety rounding observations will be performed and be an oversight guide as to the continuous and reliable operating conditions of the facility sprinkler heads.</p> <p>Monitoring will occur weekly times 4 weeks and then monthly as per the facility's' Preventive Maintenance Life rounding schedule. Results of the monitor rounding will be reported monthly to the Administrator and the Quality Assurance Committee.</p> <p>Plan of Correction date : 6/11/14</p>	06/07/2014	

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	<p>facility failed to ensure 1 of 1 oxygen supply storage rooms was separated by construction with a one hour fire rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a)2 requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. Furthermore, sprinklered hazardous areas such as the oxygen storage room are required to be equipped with self closing doors and the door is required to latch. This deficient practice affects any visitor or resident in the adjacent area and 4 or more staff in the kitchen adjoining the storage room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/20/14 at 1:55 p.m., six large liquid oxygen containers were stored in the oxygen storage supply room. The room shared a wall with the kitchen and was accessed from a door on the building's exterior. The door was constructed of metal with a Styrofoam core. The metal had rusted and a two by eighteen inch section of missing metal left the Styrofoam insulation exposed. Other smaller sections of the door had corroded away leaving smaller areas of the Styrofoam exposed. The</p>		<p>The facility strives to provide safe storage and seperation construction of at least a 1 hour fire rating.</p> <p>The facility has a new door on order that meets all NFPA 99, 8-3.1.11.1 specifications this door is set to be installed when installed on 6/7/14.</p> <p>Preventative Maintenance Life Safety rounds will be done weekly times one month to ensure that compliance is being accomplished per facility protocol, state and federal regulations.</p> <p>Monitoring of Medical gas storage and administration areas will be preformed during monthly walk thru inspections and the results reported to the Administrator and the Quality Assurance Committee.</p> <p>Plan of Correction date: 6/7/14</p>	

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K010147 SS=D	<p>maintenance director agreed at the time of observation, the door's exposed core would provide fuel in the event of fire.</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 Based on observation and interview, the facility failed to maintain electrical outlets in 1 of 3 smoke compartments. NFPA 101, 19.5.1 requires utilities to comply with Section 9.1. NFPA 101, 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects visitors, staff and two residents in physical therapy room B and occupants of the DON's office.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/20/14 between 1:35 p.m. and 1:45 p.m., an electrical receptacle in physical therapy</p>	K010147	<p>K 147</p> <p>The facility strives to adhere to electrical and wiring equipment standards within NFPA 70, National Electrical Code. 9.1.2</p> <p>The facility strives to ensure that the electrical and wiring equipment in the facility meets and is camtained properly per the state and federal regulations.</p> <p>The electral receptacle in the physical therapy room B and also in the Directector of Nursing's office have been corrected by being overed with faceplates, on 6/3/14</p> <p>The correction of these items leaves</p>	06/03/2014

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	room B and one in the DON's office were observed to be uncovered. The maintenance director acknowledged at the time of observations, the wiring should have been covered with faceplates. 3.1-19(b)		no further potential for others to be affected. The Maintenance Director and/or his designee will do weekly rounds through out the facility to aide in the prevention of any other non compliance, rounds will continue for 4 weeks, any issues that arise will be corrected immediately. Further monitoring will be done thru Preventative Maintenance Life Safety checks bi weekly times 4 more weeks and the monthly. Results will also be monitored monthly by the Administrator and the Quality Assurance Committee. Plan of Correction date: 6/3/14		