

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  06/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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
K0000	<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: 06/07/12</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 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</p>	K0000	Submission of this plan of correction shall not constitute or be construed as an admission by Ben Hur Home that the allegations in this survey report are accurate or reflect accurately the provision of services to the residents of Ben Hur Home.	

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  06/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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>determined to be of Type V (111) construction and fully sprinklered. All construction was completed prior to March 3, 2003. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. Smoke detectors were not provided in the resident rooms. The facility has the capacity for 110 and had a census of 81 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/08/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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  06/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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
K0020 SS=E	<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>Based on observation and interview, the facility failed to ensure 1 of 2 vertical stairway openings was enclosed with construction having at least a one hour fire resistance. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 7.1.3.2.1 requires openings in the separation be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. 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 visitors, staff and any residents in Wing 1 which includes administration offices and the main entry.</p> <p>Findings include:</p>	K0020	<p>I. The stairway door separating Wing 1 from the basement level has now been equipped with latching hardware which allows the door to latch into the door frame. II. All other stairways and vertical openings between floors have been assessed to ensure they latch properly. III. The Environmental Services Director will monitor during monthly building rounds to ensure that all stairway doors and vertical openings throughout the building latch properly when closed. Any necessary changes/adjustments will be made as appropriate, and reported to the Administrator. IV. As a means of quality assurance, the Administrator will review monthly building round reports and report to the Quality Assurance Committee during quarterly meetings any failure of stairway doors and/or vertical openings between floors to latch properly when closed. Attached is a picture of the latching hardware on the door separating Wing 1 from the basement level. Also attached is the monitoring tool to be utilized to ensure continued compliance each month. Based on evidence</p>	06/18/2012

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  06/07/2012	
NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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			
	Based on observation on 06/07/12 at 3:10 p.m. with the maintenance director, the stairway door separating Wing one from the basement level maintenance and facility services areas was not provided with latching hardware to allow the door to latch into the door frame. The maintenance director said at the time of observation, the latch had been removed.  3.1-19(b)		submitted, Ben Hur Home is requesting paper compliance for this citation.				

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  06/07/2012	
NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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			
K0021 SS=E	<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 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 2 of 10 doors to hazardous areas, such as a kitchen and fuel fired furnace rooms were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 7 or more residents in the Wing 7 smoke compartment.</p> <p>Findings include:</p> <p>1. Based on observation with the maintenance director on 06/07/12 at 2:00 p.m., one door in the double door set separating the kitchen from Wing 7 failed to</p>	K0021	<p>I. 1. The door coordinator at the fire doors separating the kitchen from Wing7 has been adjusted, and is now functioning properly. 2. We believe this observation was made on the Wing 10 hallway, rather than the basement, as per notes made by the Maintenance Director on the door to the mechanical room on Wing 10 drug the floor and did not close properly during the tour with the surveyor. This door has now been adjusted and does close properly when released. II. All other doors to hazardous areas and fire doors have been assessed to ensure that they close and latch properly. III. The Environmental Services Director will monitor during monthly building rounds to ensure that all fire doors and doors to hazardous areas close properly. Any necessary changes/adjustments</p>	06/12/2012			

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  06/07/2012
NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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>close when tested twice to ensure its proper operation. The door coordinator held the door with the astragal open, the second door closed and the coordinator failed to release the first door leaving an eight inch gap. The maintenance supervisor acknowledged at the time of observations the coordinator was malfunctioning.</p> <p>2. Based on observation with the maintenance director on 06/07/12 at 2:35 p.m., the self closing door to the basement mechanical room housing fuel fired equipment could not self close when opened. The door dragged on the floor and the door had to be pulled to overcome the force of the floor holding it open. Maintenance director said at the time of observation, the door needed repair to self close.</p> <p>3.1-19(b)</p>		<p>will be made as appropriate and reported to the Administrator. IV. As a means of quality assurance, the Administrator will review monthly building round reports and report to the Quality Assurance Committee during quarterly meetings any failure of fire doors or doors to hazardous areas to close properly. Attached is a picture of the adjusted door coordinator at the fire doors separating the kitchen from Wing 7. Also attached is the monitoring tool to be utilized to ensure continued compliance. Based on evidence submitted, Ben Hur Home is requesting paper compliance for this citation.</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  06/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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
K0046 SS=D	<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 1 of 3 basement battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice affects visitors, and 2 or more staff in the basement maintenance and building services area..</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/07/12 at 2:50 p.m., the battery powered emergency light near room 34 failed to illuminate when tested twice. The maintenance director said at the times of observation, he did not know the light was not working.</p> <p>3.1-19 (b)</p>	K0046	<p>I. The battery powered emergency light near room 34 has been replaced with a new emergency light which functions properly. II. All other battery powered emergency lights have been assessed to ensure they function properly. III. The Environmental Services Director will monitor during monthly preventive maintenance rounds to ensure that all battery powered emergency lights function properly. Any necessary repairs or replacements will be made as appropriate and reported to the Administrator. IV. As a means of quality assurance, the Administrator will review monthly preventive maintenance logs and report to the Quality Assurance Committee during quarterly meetings any failure of battery powered emergency lights to function properly. Attached is a picture of the new emergency light which replaced the defective one near room 34. Also attached is the monitoring tool to be utilized to ensure continued compliance. Based on evidence submitted, Ben Hur Home is requesting paper compliance for this citation.</p>	06/13/2012

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  06/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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
K0051 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 observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p>	K0051	<p>I. The directory for the emergency power circuit breaker box has been marked appropriately to identify the fire system circuit. The breaker has a red tape labeled "Fire Alarm". II. There is only one fire alarm circuit breaker connected to the generator emergency power. III. The Environmental Services Director will monitor during monthly building rounds that the fire alarm circuit breaker connected to the generator emergency power remains clearly labeled. If the label becomes faded or is not legible, it will be replaced appropriately. IV. As a means of quality assurance, the Administrator will review reports</p>	06/08/2012

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  06/07/2012
NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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>Based on observation with the maintenance director on 06/07/12 at 3:00 p.m., the emergency power circuit breaker box was identified to include the fire alarm system circuit breaker. The directory for the emergency power circuit breaker box had no marking. The fire system circuit could not be identified. The maintenance director said at the time of observation, he knew the fire alarm circuit breaker was connected to generator emergency power but he was unable to identify which circuit breaker it was.</p> <p>3.1-19(b)</p>		<p>of monthly building rounds and report to the Quality Assurance Committee during quarterly meetings any failure of proper label of the fire alarm circuit breaker connected to the generator emergency power. Attached is a picture of the marked fire alarm circuit breaker to the emergency generator. Also attached is a copy of the monitoring tool which will be utilized to ensure continued compliance. Based on evidence submitted, Ben Hur Home is requesting paper compliance for this citation.</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  06/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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
K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 2 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</p>	K0064	<p>I. A placard stating the fire protection system shall be activated prior to using the K-class fire extinguisher has been obtained from the contracted agency, and placed appropriately with the K-class fire extinguisher. II. There is only one K-class fire extinguisher in the facility. III. The Environmental Services Director will monitor during monthly building rounds that the placard remains appropriately placed with the K-class fire extinguisher in the kitchen. Any necessary replacement will be made as appropriate and reported to the Administrator. IV. As a means of quality assurance, the Administrator will review reports of monthly building rounds and report to the Quality Assurance Committee during quarterly meetings any failure of proper labeling of the K-class fire extinguisher in the kitchen. Attached is a picture of the placard placed with the K-class fire extinguisher in the kitchen. Also attached is a copy of the monitoring tool which will be utilized to ensure continued compliance. Based on evidence submitted, Ben Hur Home requests paper compliance of this citation.</p>	06/20/2012

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  06/07/2012
NAME OF PROVIDER OR SUPPLIER  BEN HUR HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1371-1375 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 visitors, staff and any residents using the dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/07/12 at 2:15 p.m., a placard stating the fire protection system shall be activated prior to using the K-class fire extinguisher was not found in the kitchen. The maintenance director said at the time of observation, he was unaware the sign was needed.</p> <p>3.1-19(b)</p>				