DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING 01 B. WING	10/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

(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
K 0000 Bldg. 01	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). Survey Date: 10/11/17 Facility Number: 011032 Provider Number: 155683 AIM Number: 200262860 At this Life Safety Code survey, B & B Christian Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 43 and had a census of 23 at	K 0000	Please accept this as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 10/16/17 - DA			
K 0200 SS=D Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2			
	Based on observation and interview, the facility failed to ensure 1 of over 20 corridor doors were provided with door latches requiring only one operation to open. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect two staff and visitors. Findings include:	K 0200	The second lock to the business office was removed by the maintenance supervisor. All other doors were checked for two sets of door locks. No others were found.A monitoring sheet for monthly door checks has been put in place to ensure that all doors have the correct amount of locks and they are functioning properly. This sheet will monitor all main corridor doors and will be kept in the Administrator's office. This will be monitored monthly by the Administrator, who will do a facility walkthrough to ensure that all doors and locks are correct and	11/10/2017

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	Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, the corridor door to the Business Office in the north hall was equipped with a deadbolt and a separate door lock in the door handle. Based on interview at the time of the observations, the Marketing Director agreed the aforementioned corridor door had more than one releasing operation to open the door. 3.1-19(b)		functioning properly. This will be an ongoing process conducted by the Administrator.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on record review, observation and interview; the facility failed to ensure preventative maintenance for all battery operated smoke alarms in resident rooms was performed. NFPA 101 in 4.6.12.3	K 0300	The Maintenance Supervisor has all the paperwork for the upkeep of the facility's smoke detectors. All paperwork is current for all smoke detectors.	11/10/2017

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	states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, battery operated smoke detector testing and cleaning documentation within the most recent twelve month period was not available for review. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, battery operated smoke detectors are installed in each resident room. A Kidde Model i9040 was installed on the wall in Room 19. Manufacturer's instructions affixed to the back of the smoke detector stated to test weekly and to clean the detector annually. 3.1-19(b)		Monitoring sheets are already in place for the monitoring of all facility smoke detectors. They are cleaned and checked monthly. All paperwork that is kept by the Maintenance Supervisor will be turned over to the Administrator while he is on vacation or will be out of the facility for an extended period of time. The Administrator will monitor this practice on an ongoing basis to ensure that all the paperwork is up to date and available if needed.	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons)			

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	f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to ensure 1 of 4 hazardous areas such as boiler and fuel-fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the main Electrical Room near the employee entrance by the laundry. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, two separate three inch in diameter holes for the passage of cables was noted in the ceiling of the main Electrical Room near the employee entrance by the laundry which contained one natural gas fired water heater. In addition, a two inch square hole for the passage of a one inch in diameter conduit was also noted in the ceiling of the aforementioned hazardous area. Based on interview at the time of the observations, the Marketing Director stated he agreed the holes in the ceiling of the main Electrical Room did not separate this hazardous area from other spaces by smoke resistant partitions.	K 0321	The holes in the electrical room by the employee entrance were repaired by the Maintenance Supervisor. The building was checked for other issues similar to the ones in this tag. No others were found. A monthly sheet was put in place for monthly inspection of the facility to ensure that all hazardous areas are properly separated from other spaces. This monthly sheet will be maintained and monitored by both the Administrator and the Maintenance Supervisor. They will conduct a monthly walkthrough to ensure that no other similar problem areas exist. This monitoring and walkthrough, by both, will be done on a continuous basis.	11/10/2017

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	3.1-19(b)			
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression systems was inspected	K 0324	Whitlock Pressure Washers inspects and cleans the exhaust hood every 6 months. The paperwork documenting this was in the	11/10/2017

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	semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect two staff and visitors in the kitchen. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, semiannual kitchen exhaust system inspections conducted within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b)		Maintenance Supervisor's office. Due to the age of the building, the exhaust hood in question was grandfathered in by Life Safety 19 years ago. Life Safety has annually inspected the hood and approved of its status and use since it was initially inspected and approved. All paperwork is now available. All paperwork has been copied and given to the Administrator, who will keep an extra copy of Whitlock's inspections in his office. This will ensure that the inspection records are always readily available. The Administrator will monitor this process every 6 months on an ongoing basis. He will make a copy of the inspection records and ensure that they will be readily available if needed.	

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	2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected in accordance with NFPA 96. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. Section 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of			

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	the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect two staff and visitors in the kitchen. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, documentation of semiannual kitchen exhaust system inspection within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, Whitlock had affixed a sticker to the range hood in the kitchen documenting kitchen exhaust system inspection on 07/31/17 as the only semiannual inspection conducted within the most recent twelve month period. 3.1-19(b) 3. Based on observation and interview, the facility failed to install the kitchen			

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	range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect two staff and visitors in the kitchen. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, the kitchen range hood system was missing an enclosed metal container for grease to drain into. A one inch in diameter open ended conduit was noted underneath the north end of the drip tray for the kitchen range hood system but no container was noted for the conduit to drain into. Based on interview at the time of the observations, the Marketing Director stated the kitchen range hood system was missing an enclosed metal			

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	container for grease to drain into. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. NFPA 72, Table 14.4.5 states fire alarm system components shall be tested annually. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice	K 0345	All records of the fire alarm system are current and kept in the Maintenance Supervisor's office. All could have been affected by this deficient practice. None were found to be affected. All records were reviewed by the Administrator. All records are current and up to date. The Administrator will keep a copy of all maintenance records in his office to ensure that the records will always be readily available. The Administrator will monitor his copies of the Maintenance Logs on a monthly basis to ensure that all the records are maintained properly and are up to date. This will be an	11/10/2017

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	could affect all residents, staff and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, documentation of fire alarm system initiating devices and notification appliances within the most recent twelve month period was not available for review. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after		ongoing process.	

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	installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, documentation of smoke detector sensitivity testing within the most recent two year period was not available for review. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b)			

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K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6			
	Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, the facility's fire watch plan for fire alarm system impairment was not available for review. In addition, the unavailability of the fire watch plan failed to ensure the plan included contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when	K 0346	There is a fire watch plan that has been and updated, as needed, for almost the last 17 years. The Administrator reviewed the fire watch plan to ensure that it is current and will be readily available in the future. The fire watch plan is kept in the Disaster Book at the Nurse's station. All staff will be re-inserviced over the fire watch plan, the Disaster Book, and where the book is kept. This book will be monitored on a monthly basis and updated as needed by the Administrator and the Maintenance Supervisor.	11/10/2017

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	the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________			

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	c) Water system supply source _____________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the	K 0353	**Part 1:** The Maintenance Supervisor removed the cable from the sprinkler pipe in the attic on the North end of the facility. All residents had the potential to be affected by this deficient practice. The Maintenance Supervisor checked all sprinkler pipes in the attic. None were found to have any external materials attached to them. The Maintenance Supervisor will inspect the attic quarterly, on an ongoing basis, to ensure that all sprinkler piping is unencumbered and functioning properly. He will keep a quarterly monitoring sheet to document the inspection of the attic. This sheet will be kept and maintained by the Maintenance Supervisor. The Administrator will also keep copies of these monitoring sheets for availability if the Maintenance Supervisor is unavailable. The Administrator will monitor this quarterly process on an ongoing basis to ensure that the inspections are being done, the records are being kept, and the sprinkler system	11/10/2017

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	Marketing Director at 8:55 a.m. on 10/11/17, weekly dry sprinkler system gauge inspection documentation for the most recent 52 week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for the most recent 12 month period was not available for review. Based on interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, the facility has a supervised dry sprinkler system and Koorsen Fire & Security had affixed a hanging tag at the system riser documenting control valve inspections were performed in October and December 2016 and in March and June 2017. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems,		and attic both meet Life Safety Code standards. **Part 2:** The quarterly September inspection of the sprinkler system was missed by Koorsen. Koorsen was immediately called to correct the problem. Also, a weekly sheet documenting the checking of all sprinkler system gauges has been created and will be kept and maintained by the Maintenance Supervisor. All could have been affected by these deficient practices. None were found to be affected. A quarterly sprinkler monitoring sheet has been created to ensure that no quarterly inspections of the sprinkler system are missed. This sheet will be checked quarterly each year at the beginning of the months of March, June, September, and December. The Maintenance Supervisor will use this sheet as a reminder to call Koorsen to confirm with them that an inspection is indeed scheduled for that month. If not, one will be scheduled at that time. The Maintenance Supervisor will keep and maintain both the quarterly sprinkler monitoring sheet	

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	2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the north hall. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, one electrical cable was wrapped around the entire length of the horizontal sprinkler pipe in the attic of the north hall. Based on interview at the time of the observations, the Marketing Director agreed the aforementioned sprinkler pipe location was used to support non-system components. 3.1-19(b)		and the weekly sheet documenting the checking of all sprinkler system gauges. The Administrator will also keep copies of these sheets to ensure that they are both maintained correctly, up to date, and readily available when needed. The Administrator will monitor these processes (quarterly for the quarterly sheet and bi-weekly for the weekly sheet) on an ongoing basis.	
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and			

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	other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			
	Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 23 of 23 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, the facility's fire watch plan for automatic sprinkler system impairment was not available for review. In addition, the unavailability of the fire watch plan	K 0354	There is a fire watch plan that has been put in place and updated, as needed, for nearly the last 17 years. The Administrator reviewed the fire watch plan to ensure that it is current and will be readily available in the future. The fire watch plan is kept in the Disaster Book at the Nurse's station. All staff will be re-inserviced over the fire watch plan, the Disaster Book, and where the book is kept. This book will be monitored on a monthly basis and updated as needed by the Administrator and the Maintenance Supervisor.	11/10/2017

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	failed to ensure the plan included contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the			

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	doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 20 corridor doors had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, the corridor door to the kitchen	K 0363	The door leading into the kitchen was repaired so that it would close when released. All residents could have been affected by this deficient condition. All doors were checked and repaired as needed. A monitoring sheet will be put in place where all doors will be checked monthly by the Maintenance Supervisor. The Administrator will also inspect all facility doors on his facility	11/10/2017

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	from the main dining room was stuck on the floor and had to be forcibly dragged across the floor to close the door. Based on interview at the time of the observations, the Marketing Director agreed the aforementioned corridor door had an impediment to closing and latching and would not resist the passage of smoke. 3.1-19(b)		walkthrough and monitor this overall process monthly, on a continuous basis, to ensure that all doors are properly maintained and function as required.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)			

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	Describe any mechanical smoke control system in REMARKS. 1. Based on observation and interview, the facility failed to ensure openings through 1 of 2 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a wall constructed as a smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, a one foot by eight inch section of the north hall attic smoke barrier wall above the corridor door set by the oxygen storage and transfilling room was missing. Over twenty cables passed through the opening in the attic smoke	K 0372	The holes in the ceiling were repaired by the Maintenance Supervisor. All residents had the potential to be affected by this deficient condition. The attic was checked for other areas that were affected. No other such areas were found. A quarterly monitoring sheet was put in place for the attic to be inspected on a quarterly basis.This sheet will be kept and maintained by the Maintenance Supervisor on a quarterly basis. The Administrator will also keep copies of these monitoring sheets for availability if the Maintenance Supervisor is unavailable. The Administrator will monitor this quarterly process on an ongoing basis.	11/10/2017

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	barrier wall which did not maintain the fire resistance rating of the attic smoke barrier wall. Based on interview at the time of the observations, the Marketing Director agreed the aforementioned hole did not maintain the fire resistance rating of the attic smoke barrier wall. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, two separate three inch in diameter holes for the passage of cables was noted in the ceiling of the main Electrical Room near the employee entrance by the laundry. In addition, a two inch square hole for the passage of a one inch in diameter conduit was also noted in the ceiling. Based on interview at the time of the observations, the Marketing Director stated he agreed the holes in the ceiling of the main Electrical Room door did not maintain the fire			

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	resistance rating of the ceiling smoke barrier. 3.1-19(b)			
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			
	Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 20 residents in the vicinity of the north hall corridor door	K 0374	The automatic fire alarm door was reset and fixed by the Maintenance Supervisor. All residents had the potential to be affected by this deficient condition. The other fire alarm doors were checked to ensure that they closed properly. They were found to be working and closing correctly. The Maintenance Supervisor and Administrator will conduct a monthly walkthrough of the facility to monitor for any problem areas or conditions. All facility doors will be	11/10/2017

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	set. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, the set of corridor smoke barrier doors in the north hall by the oxygen storage and transfilling room failed to close completely leaving a one inch gap in between the meeting edges of the door set. The top of both doors were hitting the door frame when attempted to close five separate times. Based on interview at the time of the observations, the Marketing Director agreed the aforementioned corridor smoke barrier door set had a one inch gap between the meeting edges of the door set. 3.1-19(b)		checked. A monthly monitoring sheet will be put in place where all doors will be checked monthly and documented to ensure that all doors are functioning properly and up to Life Safety standards. This process will be monitored monthly by the Administrator on a continuous basis to ensure that all facility doors are working properly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			

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	Based on observation and interview, the facility failed to ensure all electrical wiring in the facility was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314 states exposed terminals and receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 20 residents, staff and visitors in the north hall. Findings include: Based on observations with the Marketing Director during a tour of the facility from 9:00 a.m. to 10:10 a.m. on 10/11/17, the following was noted: a. electrical wiring wrapped around the horizontal sprinkler pipe in the attic in the north hall was spliced together near the attic access door in the north hall. The spliced wiring was not confined within a junction box with a cover compatible with the box. b. two wall mounted electrical outlets in the sprinkler system riser room in the north hall were not equipped with a cover plate. Based on interview at the time of the observations, the Marketing Director	K 0511	The wiring in the attic was repaired. A junction box was put in place and cover plates were put on the 2 exposed outlets. All could have been affected by this deficient practice. The entire attic was inspected. No other areas were found to have this problem. A quarterly inspection sheet was put in place to monitor all the electric junction boxes in the attic to ensure that they are properly maintained and functioning correctly. This record will be kept and maintained by the Maintenance Supervisor. The Administrator will keep copies of these sheets to ensure they are readily available when needed. This process will be monitored by the Maintenance Supervisor on a quarterly basis and overseen by the Administrator quarterly, on an ongoing basis, to ensure that the process is effective and being followed.	11/10/2017

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	agreed the spliced electrical wiring in the attic in the north hall was not confined within a junction box with a cover compatible with the box and the aforementioned wall outlets were missing its cover plate. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			
	Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department	K 0711	A written fire plan is always kept in the Disaster Preparedness Book at the Nurse's station. The Administrator reviewed the fire watch plan and Disaster Preparedness Book to ensure that both are current and will be readily available in the future. An inservice was given by the Maintenance Supervisor to all staff	11/10/2017

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	(3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, a written fire safety plan for the facility was not available for review. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b)		over the fire watch plan and how these records are always kept and maintained in the Disaster Preparedness Book at the Nurse's Station. The Disaster Preparedness Book will be monitored and updated as needed by the Maintenance Supervisor. The Administrator will monitor this overall process monthly, on an ongoing basis, and help with maintaining the book and keeping it up to date.	

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills 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. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first, second and third shifts for 4 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, fire drill documentation of fire drills conducted within the most recent twelve month period was not available for review. Based interview at the time of record review, the Marketing Director stated the facility operates three shifts per day and the Maintenance Director keeps all life safety records but he is on	K 0712	A fire drill book is kept by the Maintenance Supervisor. It is current and up to date. The Administrator reviewed the fire drill process and record keeping to ensure that both are current and will be readily available in the future. The Maintenance Supervisor will continue to keep and maintain the fire drill book and records. The Administrator will also keep copies of the fire drill records to ensure that they are readily available, if and when needed. This process will be monitored by the Administrator monthly, on an ongoing basis, to ensure that the fire drill records are up to date, maintained properly, and will be readily available if needed.	11/10/2017

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	vacation with the facility having no access to where his records are kept. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new			

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	installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for 52 weeks of the most recent 52 week period. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, documentation of weekly emergency generator inspections for the most recent twelve month period was not available for review. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 months of the most recent 12 month period. NFPA 99, Health Care Facilities Code, 2012 Edition, Chapter 6.4.4.1.1.4(A) requires monthly testing of	K 0918	All generator records are kept and maintained by the Maintenance Supervisor. All records are current and up to date. The Administrator reviewed the generator record keeping process to ensure that it is current and will be readily available in the future. The Maintenance Supervisor will continue to keep and maintain the weekly generator records. The Administrator will also keep copies of the generator records to ensure that they are readily available when needed. This process will be monitored by the Administrator bi-weekly, on an ongoing basis, to ensure that the generator records are maintained properly, up to date, and readily available when/if needed.	11/10/2017

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	the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 2010 Edition, Section 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. (2) Under operating temperature conditions and at not less than 30% of the Emergency Power Supply (EPS) nameplate kW rating. Section 8.4.2.3 requires diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient			

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	practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the Marketing Director at 8:55 a.m. on 10/11/17, emergency generator load testing documentation for the most recent twelve month period was not available for review. Based interview at the time of record review, the Marketing Director stated the Maintenance Director keeps all life safety records and he is on vacation with the facility having no access to where his records are kept. 3.1-19(b)			