PRINTED:	11/13/2018
FORM APP	ROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	ENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155683 155683		(X2) MULTIPLE CO A. BUILDING B. WING	<u></u>	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 10/18/2018
	PROVIDER OR SUPPLIER		3208 N	address, city, state, zip cod I SHERMAN DR IAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
E 0000					
Bldg	conducted by the In	paredness Survey was diana State Department of we with 42 CFR 483.73.	E 0000	Please accept this as our credi allegation of compliance.	ible
	Survey Date: 10/18	8/18			
	Facility Number: 0 Provider Number: AIM Number: 2002	155683			
	Christian Healthcard substantial complian Preparedness Requi	Preparedness survey, B & B e Center was found in nce with Emergency rements for Medicare and ing Providers and Suppliers, 42			
	The facility has 43 of the survey, the cens	certified beds. At the time of us was 24.			
	Quality Review con	npleted on 10/22/18 - DA			
	The requirement at MET as evidenced	42 CFR, Subpart 483.73 is NOT by:			
E 0015 SS=C Bldg					
	failed to ensure eme and procedures incl provision of subsist residents, whether ti place, include, but a (i) Food, water, med supplies. (ii) Alterna	view and interview, the facility ergency preparedness policies ude at a minimum, (1) The ence needs for staff and hey evacuate or shelter in are not limited to the following: dical, and pharmaceutical ate sources of energy to peratures to protect resident	E 0015	Tox Drop (a waste removal company) was called and a wa removal plan was put into place The plan calls for them to be available to remove all sewage waste in the event of a disaster All hazardous waste will be put cardboard boxes or plastic containers.	e. e and r.

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 X2) MULTIPLE CONSTRUCTI DENTIFICATION NUMBER A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155683	A. BUI B. WIN				8/2018
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD	1	
B&BCH	RISTIAN HEALTH	ICARE CENTER			POLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nd for the safe and sanitary			All could have been affected i	f	
		ons; (B) Emergency lighting; (C)			there had been a disaster.		
		inguishing, and alarm systems;			The Administrator will touch b	ase	
		nd waste disposal in accordance			with Tox Drop to quarterly to		
		73(b)(1). This deficient practice			ensure that they are still avail		
	could affect all occ	cupants.			to remove waste and sewage	if	
					needed.		
	Findings include:				This will be monitored quarter the Administrator and	ly by	
	Based on review o	f "Disaster Preparedness Plan"			Maintenance Supervisor on a	n	
	documentation wit	h the dated $01/04/18$ with the			ongoing basis.		
	Director of Nursin	g (D.O.N.), the Social Worker			5 5		
	and the Maintenan	ce Supervisor during record					
	review from 9:15 a	a.m. to 12:25 p.m. on 10/18/18,					
	subsistence needs	documentation for the					
	emergency prepare	edness program was incomplete.					
	The documentation	n did not include subsistence					
	needs for sewage a	and waste disposal during an					
		ster. Based on interview at the					
	time of record revi	ew, the D.O.N. and the					
		rvisor Director stated the					
	~	nt contract for waste disposal					
		ncy preparedness program					
		not include subsistence needs					
	for sewage and wa	ste disposal during an					
	emergency or disas						
E 0022							
SS=C							
Bldg							
		eview and interview, the facility	E 002		A new policy and procedure f		11/05/201
		nergency preparedness policies			sheltering in place, taken fron	n the	
	-	clude a means to shelter in place			new disaster preparedness		
		, and volunteers who remain in			manual, has been implemente		
	-	accordance with 42 CFR			All residents had the potentia	l to	
	483.73(b)(4). This	deficient practice could affect all			be affected by this deficient		
	occupants.				practice.		
					The Maintenance Supervisor	had	
	Findings include:				an inservice over disaster		
					preparedness and used the n	ew	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155683		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		X3) DATE SURVEY COMPLETED 10/18/2018	
	NAME OF PROVIDER OR SUPPLIER B & B CHRISTIAN HEALTHCARE CENTER		3208 N	ADDRESS, CITY, STATE, ZIP COD I SHERMAN DR JAPOLIS, IN 46218	
	-			1	(175)
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
0024	documentation with Director of Nursin and the Maintenan review from 9:15 a documentation of a policies and procee volunteers who ren an emergency was on interview at the D.O.N. and the Ma the facility does not emergency prepared not include docum preparedness polic sheltering in place LTC facility durin	f "Disaster Preparedness Plan" the the dated 01/04/18 with the g (D.O.N.), the Social Worker ce Supervisor during record a.m. to 12:25 p.m. on 10/18/18, emergency preparedness dures for sheltering in place main in the LTC facility during not available for review. Based et time of record review, the aintenance Supervisor stated of use volunteers but agreed the edness plan for the facility did entation of emergency ties and procedures for volunteers who remain in the g an emergency was not w at the time of the survey.		disaster preparedness manual t update our policy and procedur He informed all staff of the new requirements for disaster preparedness and sheltering in place. This will be monitored quarterly the Administrator and the Maintenance Supervisor on an ongoing basis.	es.
SS=C Bldg	 failed to ensure en and procedures ind an emergency or o strategies, includir integration of State care professionals an emergency in a 483.73(b)(6). This all occupants. Findings include: Based on review o documentation with Director of Nursin and the Maintenan 	eview and interview, the facility hergency preparedness policies clude the use of volunteers in ther emergency staffing ag the process and role for e or Federally designated health to address surge needs during coordance with 42 CFR s deficient practice could affect f "Disaster Preparedness Plan" th the dated 01/04/18 with the g (D.O.N.), the Social Worker ce Supervisor during record a.m. to 12:25 p.m. on 10/18/18, the	E 0024	A new policy, on staffing and volunteers during an emergency has been written. It also include the police, the fire department, and other healthcare profession from other areas if they are needed. All could have been affected if a disaster had occurred. This policy was incorporated int the inservice on disaster preparedness. This inservice w be given to all new employees upon hire and quarterly to all employees thereafter. This will be inserviced and monitored quarterly by the Administrator and Maintenance	ed nals a to vill

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NTERS FOR	R MEDICARE & MEDIC	CAID SERVICES					MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/18/2018	
	of conduction,	155683	B. W				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
B & B CH	RISTIAN HEALTH	ICARE CENTER			SHERMAN DR IAPOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
		dness plan for the facility did			Supervisor on an ongoing b	asis.	
		of volunteers in an emergency					
	or other emergency	staffing strategies. Based on					
	interview at the tin	ne of record review, the D.O.N.					
	and the Maintenan	ce Supervisor stated the					
	-	e volunteers but agreed the					
	·	licy did not address the use of					
		nergency or other emergency					
	staffing strategies.						
0039							
0039 SS=C							
31dg							
Jug	Based on record re	view and interview, the facility	E 0	020	A new policy, on staffing an	ч	11/05/201
		xercises to test the emergency	E U	039	volunteers during an emerg		11/03/201
		lly, including unannounced			has been written. It also inc	-	
	-	e emergency procedures. The			the police, the fire departme		
		do all of the following: (i)			and other healthcare profes		
	-	-scale exercise that is			from other areas if they are		
	community-based	or when a community-based			needed.		
	exercise is not acce	essible, an individual,			All could have been affected	d if a	
	facility-based. If the	he LTC facility experiences an			disaster had occurred.		
		an-made emergency that			This policy was incorporate	d into	
	-	of the emergency plan, the			the inservice on disaster		
		mpt from engaging in a			preparedness. This inservi		
	-	or individual, facility-based			be given to all new employe		
		for 1 year following the onset of			upon hire and quarterly to a	II	
		i) conduct an additional			employees thereafter.		
	-	nclude, but is not limited to the cond full-scale exercise that is			This will be inserviced and		
		or individual, facility-based. (B)			monitored quarterly by the Administrator and Maintena	200	
		that includes a group			Supervisor on an ongoing b		
		facilitator, using a narrated,				u313.	
		emergency scenario, and a set					
	-	ents, directed messages, or					
	-	designed to challenge an					
		ii) analyze the LTC facility's					
		intain documentation of all					
	-	rcises, and emergency events,					
		facility's emergency plan, as					1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED B. WING 10/18/2018 155683 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3208 N SHERMAN DR INDIANAPOLIS, IN 46218 **B & B CHRISTIAN HEALTHCARE CENTER** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Preparedness Plan" documentation with the dated 01/04/18 with the Director of Nursing (D.O.N.), the Social Worker and the Maintenance Supervisor during record review from 9:15 a.m. to 12:25 p.m. on 10/18/18, documentation for testing the facility's emergency preparedness program twice within the most recent twelve month period was not available for review. Based on interview at the time of record review, the D.O.N. and the Maintenance Supervisor stated there has been fire department runs to the facility within the last year but none of the runs were documented as a test of the facility's emergency preparedness program. In addition, the Social Worker stated they have an actual elopement documented with police department involvement in July 2017 but the Social Worker agreed the documented man-made emergency occurred more than one year ago. Based on interview at the time of record review, the D.O.N., the Social Worker and the Maintenance Supervisor agreed the facility has not conducted a community based disaster drill or experienced and documented a natural or man-made emergency that requires activation of the emergency plan or conducted and documented a tabletop exercise within the most recent twelve month period. K 0000 Bldg. 01 A Life Safety Code Recertification and State K 0000 Please accept this as our credible Licensure Survey was conducted by the Indiana allegation of compliance. State Department of Health in accordance with 42 Event ID: QCFW21 Facility ID: 011032 Page 5 of 13 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. BUILDING <u>01</u> 155683 B. WING			X3) DATE SURVEY COMPLETED 10/18/2018	
	PROVIDER OR SUPPLIE		3208 N	ADDRESS, CITY, STATE, ZIP COD SHERMAN DR)	
B & B C	HRISTIAN HEALTH	ICARE CENTER	INDIAN	IAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	CFR 483.90(a).					
	Survey Date: 10/1	8/18				
	Facility Number: Provider Number: AIM Number: 20	155683				
	Healthcare Center with Requirement Medicare/Medicai Life Safety from F National Fire Prot Life Safety Code (Code survey, B & B Christian was found not in compliance s for Participation in d, 42 CFR Subpart 483.90(a), Fire and the 2012 edition of the ection Association (NFPA) 101, LSC), Chapter 19, Existing pancies and 410 IAC 16.2.				
	Type V (111) con: The facility has a detection in the co the corridor. The smoke detectors in	ility was determined to be of struction and fully sprinklered. fire alarm system with smoke rridors and in all areas open to facility has battery operated a all resident sleeping rooms. capacity of 43 and had a census f this survey.				
	were sprinklered.	sidents have customary access The facility has two detached g facility storage services rinklered.				
	Quality Review co	ompleted on 10/22/18 - DA				
< 0345 SS=F Bldg. 01						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/18/2018 155683 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3208 N SHERMAN DR **B & B CHRISTIAN HEALTHCARE CENTER** INDIANAPOLIS. IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility K 0345 Koorsen came on November 1. 11/05/2018 failed to ensure 1 of 1 fire alarm systems was 2018 and completed the sensitivity maintained in accordance with 9.6.1.3. LSC 9.6.1.3 test. requires a fire alarm system to be installed, tested, All others could have been and maintained in accordance with NFPA 70, affected by this deficient practice. National Electrical Code and NFPA 72, National Koorsen sent a list of all the Fire Alarm Code. NFPA 72, Section 14.5 requires testing dates for the next year and testing shall be performed in accordance with the will renew them annually. This will Table 14.4.5 Testing Frequencies. NFPA 72, give the Maintenance Supervisor a Section 14.4.5.3.1 states sensitivity shall be chance to interact with Koorsen checked within 1 year after installation. NFPA 72, when testing is due and will help Section 14.4.5.3.2 states sensitivity shall be ensure that no testing is missed. checked every alternate year thereafter unless This will be monitored by the otherwise permitted by compliance with 14.4.5.3.3. Maintenance Supervisor and NFPA 72, Section 14.4.5.3.5 states smoke Administrator weekly on an detectors or smoke alarms found to have a ongoing basis. sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Supervisor from 9:15 a.m. to 12:25 p.m. on 10/18/18, documentation of sensitivity testing conducted within the most recent two year period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor tried to obtain sensitivity testing documentation for testing conducted within the most recent two year period which he was unable to obtain and agreed sensitivity testing documentation for sensitivity testing conducted Facility ID: 011032

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155683	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 10/18/2018	
	PROVIDER OR SUPPLIE		3208	T ADDRESS, CITY, STATE, ZIP COD N SHERMAN DR NAPOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION cent two year period was not	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
< 0353 SS=F Bldg. 01	Sprinkler System Automatic sprink	w. - Maintenance and Testing - Maintenance and Testing ler and standpipe systems sted, and maintained in				
	Inspection, Testi Water-based Fire Records of syste inspection and te secure location a					
	Provide in REMA coverage for any automatic sprink 9.7.5, 9.7.7, 9.7.4 1. Based on recor facility failed to de inspections in acce 25, Standard for th Maintenance of W Systems, 2011 Ed gauges on dry pipe inspected weekly to water pressures an 5.1.2 states valves connections shall 1 maintained in acce Section 13.1.1.2 st	RKS information on non-required or partial er system.	K 0353	The March sprinkler syster was missed. Koorsen was and was asked to send a li all testing to be done for th year. They explained that had a change in personnel apologized for the missed The list of inspection dates available so that the Mainte Supervisor can follow up o dates of inspections more The Maintenance Supervis weekly check list in place t check the sprinkler system	a called st with at they and date. will be enance n due readily. sor put a o	11/05/2018

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155683	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 01	(X3) DATE COMPI 10/18	
NAME OF PROVIDER OR SUPP 3 & B CHRISTIAN HEAL		3208 N	ADDRESS, CITY, STATE, ZIP COI SHERMAN DR IAPOLIS, IN 46218)	
X4) IDSUMMAPREFIX(EACH DEFIGTAGREGULATORValves, valve constantsstates records slitests, and mainticcomponents and authority having deficient practice and visitors.Findings includBased on review"Sprinkler Inspected dated 11/03/17documentation 09/11/18 with the record review fr 10/18/18, the fat and weekly dry documentation week period wat addition, monthe all sprinkler system months of the nit was also not available for addition performed by the agreed weekly site system control in documented by contractor inspectionX4) IDSUMMA Present System control in documented by contractor inspectionX4) IDSummer System control in system control in 	RY STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY FULL <u>OR LSC IDENTIFYING INFORMATION</u> mponents and trim. Section 4.3.1 all be made for all inspections, enance of the system and its shall be made available to the gjurisdiction upon request. This e could affect all residents, staff, e could affect all residents, staff, could affect all residents, staff, e could affect all residents, staff, down Report" documentation and "Systems Service" lated 01/04/18, 06/07/18 and e Maintenance Supervisor during om 9:15 a.m. to 12:25 p.m. on cility has a dry sprinkler system sprinkler system gauge inspection for 48 weeks of the most recent 52 s not available for review. In by inspection documentation for teem control valves for eight ost recent twelve month period ilable for review. Based on time of record review, the pervisor stated the facility has stems and he frequently conducts as of sprinkler system gauges and on to the quarterly inspections e sprinkler system contractor but prinkler gauge and monthly alve inspections are not the facility outside of the four ctions performed within the most	ID PREFIX TAG	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY) All could have been affect this deficient practice. The Administrator will go list of test dates sent by I and the weekly checklist by the Maintenance Supe ensure that all tests and inspections are being cou This will be monitored we the Maintenance Superv Administrator on an ongo basis.	Cted by over the Koorsen created ervisor to mpleted. eekly by isor and	(X5 COMPLE DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID:

QCFW21 Facility ID: 011032

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155683	(X2) MULTIPLE C A. BUILDING B. WING	<u>01</u>	x3) date survey completed 10/18/2018
	PROVIDER OR SUPPLIE HRISTIAN HEALTH		3208 N	ADDRESS, CITY, STATE, ZIP COD N SHERMAN DR NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR 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
		n did not document any ow alarm inspections between 7/18.			
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space I Portable Space I Portable Space I prohibited in all f except, unless u employee areas do not exceed 2 degrees Celsius 18.7.8, 19.7.8 Based on observat failure to ensure 1 were not used in 1 containing resider practice could affe visitors in the vici resident Room 14 compartment. Findings include: Based on observat Supervisor during p.m. to 1:15 p.m. o portable space heat the Business Offic north smoke comp resident sleeping n space heater was p the floor in the roo affixed to the port the maximum hea achieved by the un	Heaters leating devices shall be nealth care occupancies, sed in nonsleeping staff and where the heating elements 12 degrees Fahrenheit (100	K 0781	The space heaters in question were immediately disconnected All residents had the potential to be affected by this deficient practice. No electrical heaters will be used in areas adjacent to resident's rooms. This will be monitored on an ongoing basis by the Administrator and Maintenance Supervisor on their daily walk through.	o ed

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155683 B. WING 10/18/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3208 N SHERMAN DR **B & B CHRISTIAN HEALTHCARE CENTER** INDIANAPOLIS. IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Supervisor stated he was unaware of the maximum temperature achieved by the portable space heater and agreed the unit was in use in a smoke compartment containing resident sleeping rooms. 3.1-19(b) K 0920 **NFPA 101** SS=E Electrical Equipment - Power Cords and Bldg. 01 Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by gualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 All extension and power cords 11/05/2018 failed to ensure 1 of 1 extension cords including were removed. power strips and non-fused multiplug adapters All residents had the potential to were not used as a substitute for fixed wiring. be affected but none were found. LSC 19.5.1 requires utilities to comply with Section The Maintenance Supervisor QCFW21 Event ID: Facility ID: 011032 Page 12 of 13 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/13/2018

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155683		A. BUILDING <u>01</u> B. WING				COMPLETED 10/18/2018	
NAME OF PROVIDER OR SUPPLIER B & B CHRISTIAN HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3208 N SHERMAN DR INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OD 9.1. LSC 9.1.2 req equipment to comp Electrical Code, 20 400.8 requires that, flexible cords and of substitute for fixed Section 4.5.7 states equipment or safeg shall be designed, if accordance with all This deficient pract residents, staff and Business Office by smoke compartment Findings include: Based on observati Supervisor during a p.m. to 1:15 p.m. of portable space heat the Business Office plugged into a pow also plugged into the Based on interview observations, the M a power strip was b	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION uires electrical wiring and ally with NFPA 70, National 11 Edition. NFPA 70, Article , unless specifically permitted, cables shall not be used as a wiring of a structure. LSC any building service uard provided for life safety nstalled and approved in l applicable NFPA standards. tice could affect over 10 visitors in the vicinity of the resident Room 14 in the north nt. ons with the Maintenance a tour of the facility from 12:25 n 10/18/18, an operating er was in use on the floor in e by resident Room 14 and was rer strip. A refrigerator was ne power strip in the room.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) removed all power cords a extension cords from the fa This will be monitored by th Administrator and Mainten Supervisor on their daily w through.	nd acility. he ance	(X5) COMPLETION DATE
	3.1-19(b)						

QCFW21 Facility ID: 011032

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