STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155683	A. BUILDING -- B. WING	10/18/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/18/18 Facility Number: 011032 Provider Number: 155683 AIM Number: 200262860 At this Emergency Preparedness survey, B & B Christian Healthcare Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 43 certified beds. At the time of the survey, the census was 24. Quality Review completed on 10/22/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Please accept this as our credible allegation of compliance.	
E 0015 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident	E 0015	Tox Drop (a waste removal company) was called and a waste removal plan was put into place. The plan calls for them to be available to remove all sewage and waste in the event of a disaster. All hazardous waste will be put in cardboard boxes or plastic containers.	11/05/2018

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

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	health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). 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, subsistence needs documentation for the emergency preparedness program was incomplete. The documentation did not include subsistence needs for sewage and waste disposal during an emergency or disaster. Based on interview at the time of record review, the D.O.N. and the Maintenance Supervisor Director stated the facility has a current contract for waste disposal but agreed emergency preparedness program documentation did not include subsistence needs for sewage and waste disposal during an emergency or disaster.		All could have been affected if there had been a disaster. The Administrator will touch base with Tox Drop to quarterly to ensure that they are still available to remove waste and sewage if needed. This will be monitored quarterly by the Administrator and Maintenance Supervisor on an ongoing basis.	
E 0022 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include:	E 0022	A new policy and procedure for sheltering in place, taken from the new disaster preparedness manual, has been implemented. All residents had the potential to be affected by this deficient practice. The Maintenance Supervisor had an inservice over disaster preparedness and used the new	11/05/2018

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	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 of emergency preparedness policies and procedures for sheltering in place volunteers who remain in the LTC facility during an emergency was not available for review. Based on interview at the time of record review, the D.O.N. and the Maintenance Supervisor stated the facility does not use volunteers but agreed the emergency preparedness plan for the facility did not include documentation of emergency preparedness policies and procedures for sheltering in place volunteers who remain in the LTC facility during an emergency was not available for review at the time of the survey.		disaster preparedness manual to update our policy and procedures. He informed all staff of the new requirements for disaster preparedness and sheltering in place. This will be monitored quarterly by the Administrator and the Maintenance Supervisor on an ongoing basis.	
E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). 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, the	E 0024	A new policy, on staffing and volunteers during an emergency, has been written. It also included the police, the fire department, and other healthcare professionals from other areas if they are needed. All could have been affected if a disaster had occurred. This policy was incorporated into the inservice on disaster preparedness. This inservice will 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	11/05/2018

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	emergency preparedness plan for the facility did not include the use of volunteers in an emergency or other emergency staffing strategies. Based on interview at the time of record review, the D.O.N. and the Maintenance Supervisor stated the facility does not use volunteers but agreed the aforementioned policy did not address the use of volunteers in an emergency or other emergency staffing strategies.		Supervisor on an ongoing basis.	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as	E 0039	A new policy, on staffing and volunteers during an emergency, has been written. It also included the police, the fire department, and other healthcare professionals from other areas if they are needed. All could have been affected if a disaster had occurred. This policy was incorporated into the inservice on disaster preparedness. This inservice will 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 Supervisor on an ongoing basis.	11/05/2018

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	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 Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42	K 0000	Please accept this as our credible allegation of compliance.	

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	CFR 483.90(a). Survey Date: 10/18/18 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 483.90(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 24 at 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 10/22/18 - DA			
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			

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	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 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, Section 14.5 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 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. NFPA 72, Section 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. 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	K 0345	Koorsen came on November 1, 2018 and completed the sensitivity test. All others could have been affected by this deficient practice. Koorsen sent a list of all the testing dates for the next year and will renew them annually. This will give the Maintenance Supervisor a chance to interact with Koorsen when testing is due and will help ensure that no testing is missed. This will be monitored by the Maintenance Supervisor and Administrator weekly on an ongoing basis.	11/05/2018

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	within the most recent two year period was not available for review. 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 _____ 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 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	K 0353	The March sprinkler system test was missed. Koorsen was called and was asked to send a list with all testing to be done for that year. They explained that they had a change in personnel and apologized for the missed date. The list of inspection dates will be available so that the Maintenance Supervisor can follow up on due dates of inspections more readily. The Maintenance Supervisor put a weekly check list in place to check the sprinkler system.	11/05/2018

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	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 review of Koorsen Fire & Security "Sprinkler Inspection Report" documentation dated 11/03/17 and "Systems Service" documentation dated 01/04/18, 06/07/18 and 09/11/18 with the Maintenance Supervisor during record review from 9:15 a.m. to 12:25 p.m. on 10/18/18, the facility has a dry sprinkler system and weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 week period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for eight months of the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has dry sprinkler systems and he frequently conducts visual inspections of sprinkler system gauges and valves in addition to the quarterly inspections performed by the sprinkler system contractor but agreed weekly sprinkler gauge and monthly system control valve inspections are not documented by the facility outside of the four contractor inspections performed within the most recent twelve month period. 3.1-19(b) 2. Based on record review, observation and interview, the facility failed to document sprinkler		All could have been affected by this deficient practice. The Administrator will go over the list of test dates sent by Koorsen and the weekly checklist created by the Maintenance Supervisor to ensure that all tests and inspections are being completed. This will be monitored weekly by the Maintenance Supervisor and Administrator on an ongoing basis.	

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	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 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system 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 review of Koorsen Fire & Security "Systems Service" documentation dated 01/04/18 and 06/07/18 with the Maintenance Supervisor during record review from 9:15 a.m. to 12:25 p.m. on 10/18/18, it had been 150 calendar days in between documented sprinkler system waterflow alarm inspections in the first six months of 2018. Based on interview at the time of record review, the Maintenance Supervisor tried to obtain additional sprinkler system inspection documentation from Koorsen for the first six months of 2018 which he was unable to obtain and agreed the inspections were not conducted quarterly as it had been greater than 90 days in between documented sprinkler system waterflow alarm inspections for the first two calendar quarters of 2018. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:25 p.m. to 1:15 p.m. on 10/18/18, Koorsen had affixed hanging tags to the sprinkler			

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	system riser which did not document any additional water flow alarm inspections between 01/04/18 and 06/07/18. 3.1-19(b)			
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in 1 of 2 smoke compartments containing resident sleeping areas. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Business Office by resident Room 14 in the north smoke compartment. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:25 p.m. to 1:15 p.m. on 10/18/18, an operating portable space heater was in use on the floor in the Business Office by resident Room 14 in the north smoke compartment which contained resident sleeping rooms. The electric portable space heater was plugged into a power strip on the floor in the room. Manufacturer's information affixed to the portable space heater did not state the maximum heating element temperature achieved by the unit. Based on interview at the time of the observations, the Maintenance	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.	11/05/2018

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	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 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and 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 qualified 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 failed to ensure 1 of 1 extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section	K 0920	All extension and power cords were removed. All residents had the potential to be affected but none were found. The Maintenance Supervisor	11/05/2018

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B & B CHRISTIAN HEALTHCARE CENTER	3208 N SHERMAN DR INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Business Office by resident Room 14 in the north smoke compartment. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 12:25 p.m. to 1:15 p.m. on 10/18/18, an operating portable space heater was in use on the floor in the Business Office by resident Room 14 and was plugged into a power strip. A refrigerator was also plugged into the power strip in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location. 3.1-19(b)		removed all power cords and extension cords from the facility. This will be monitored by the Administrator and Maintenance Supervisor on their daily walk through.	