

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155487	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/15/2014
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NAME OF PROVIDER OR SUPPLIER  BROWN COUNTY HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 55 E WILLOW ST NASHVILLE, IN 47448
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/15/14</p> <p>Facility Number: 000479 Provider Number: 155487 AIM Number: 100290880</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brown County Health and Living Community was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 01 and Building 02 were surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility consists of two sections: the original buildings, Building 01 and 02, were determined to be of Type V (111) construction and fully sprinklered. Building 03, the new</p>	K010000	<p>This plan of correction is to serve as Brown County Health and Living Community's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Brown County Health and Living Community, or its management company, that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010015 SS=E	<p>Therapy Room and adjoining support rooms built in 2011, is of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has hard wired smoke detectors in resident sleeping rooms E8 through E14 and has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 117 and had a census of 103 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage buildings which were not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and</p>			

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K010025 SS=E	<p>ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation of the flame spread rating for interior finish materials installed in 1 of over 75 rooms. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Mechanical/Boiler Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 09/15/14, a one foot by one foot section of drywall near the floor of the Mechanical/Boiler Room was missing which exposed a wood stud on the room side of the wall. Based on interview at the time of observation, the Maintenance Director acknowledged flame spread rating documentation was not available for review for the exposed wood stud in the Mechanical/Boiler Room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K010015	<p><u>K015</u></p> <p>1.Theone foot by one foot section of drywall in the boiler room has been replaced.</p> <p>2.Allother areas of drywall in the boiler room were inspected and were found to befree from any missing drywall.</p> <p>3.Missingdrywall has been added to the Preventative Maintenance schedule requiring theMaintenance Director or his designee to inspect all boiler room walls formissing drywall and repair them immediately.</p> <p>4.Resultsof these inspections will be submitted to the Quality Assurance Committee everymonth for one year.</p>	09/29/2014

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	<p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 2 of 11 smoke barrier walls were protected to maintain the one half hour fire resistance of the smoke barrier. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 40 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 09/15/14, the following was noted:</p>	K010025	<p><u>K025</u></p> <p>1. Fire Caulk has been applied to the gaps around the pipes and the cable wires in the C Hall and E Hall entrance smoke barrier attic walls cited in this deficiency.</p> <p>2. All other firewalls will be inspected and gaps around the sprinkler pipes and data wires will be filled with fire caulk as needed. Building repair and maintenance vendors will be notified, upon any need for service that may disrupt the integrity of the fire caulk, to report any need to replace fire caulk.</p> <p>3. Firewall inspection has been added to the Preventative Maintenance schedule requiring the Maintenance Director or his designee to inspect fire walls once a month to make sure all penetration gaps in facility firewalls are fire caulked.</p> <p>4. Results of these inspections will be submitted to the Quality Assurance Committee every month for a year.</p>	09/29/2014	

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	<p>a. a three inch by one inch hole for the passage of one half inch in diameter pipe and a two inch in diameter hole for the passage of a one inch in diameter pipe and four cables were noted in the smoke barrier wall above the ceiling by the C Hall entrance smoke barrier door set which did not provide at least a one half hour fire resistance rating for the smoke barrier wall.</p> <p>b. a three inch in diameter hole for the passage of a two inch in diameter pipe and a two inch in diameter hole for the passage of a one inch in diameter pipe were noted in the smoke barrier wall in the attic above the C Hall entrance smoke barrier door set which did not provide at least a one half hour fire resistance rating for the smoke barrier wall.</p> <p>c. a four inch in diameter hole for the passage of ten cables was noted in the smoke barrier wall in the attic above the E Hall entrance smoke barrier door set which did not provide at least a one half hour fire resistance rating for the smoke barrier wall.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the openings in the aforementioned smoke barrier walls did not provide at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p>						

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 20 residents, staff and visitors if needing to exit the facility by proceeding into the C Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 09/15/14, the entrance to C Hall by the</p>	K010038	<p><u>K038</u></p> <p>1.The4-digit entrance code has been posted at the entry door to the C Hall. The Fire Alarm system continues to releasethe magnetic lock on the door in the event the fire alarm system is triggered.</p> <p>2.Thereare no other magnetic-lock coded doors at the beginning of a corridor.</p> <p>3.MaintenanceDirector or his designee will inspect the C Hall entry door to make sure thecurrent entry code is posted at the door.</p> <p>4.Resultsof these inspections will be submitted to the Quality Assurance Committee everymonth for a year.</p>	09/29/2014
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K010056 SS=E	<p>nurses' station was marked as a facility exit, the cross corridor door set serving as the entrance to C Hall was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director acknowledged the entrance to C Hall by the nurses' station was marked as a facility exit and could be opened by entering a four digit code but the code was not posted.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires</p>	K010056	<p><u>K056</u></p> <p>1.Contractedservice for our Sprinkler System will install the required sprinkler heads inthe C Hall outside canopy.</p> <p>2.Facilitywill add proper sprinkler system coverage to two</p>	09/29/2014

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K010147 SS=D	<p>sprinklers shall be installed under combustable exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 09/15/14, the exterior canopy at the C Hall exit extended five feet from the building, was of wood construction and was not provided with automatic sprinklers. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned canopy extended more than four feet from the building, was of combustable construction and was not provided with automatic sprinklers.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring.</p>	K010147	<p>additional outside canopy areas as per regulation.</p> <p>3. Maintenance Director or his designee will inspect the canopy areas quarterly to ensure the sprinkler system meets code and is fully functioning.</p> <p>4. Results of these inspections will be submitted to the Quality Assurance Committee every month for a year.</p> <p><u>K147</u> 1. The oxygen concentrator and bed in Room D12 were unplugged from the power strip and plugged directly into the wall,</p>	09/29/2014			

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K030000	<p>NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect two residents, staff and visitors in the vicinity of Room D12 and the Business Office.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 09/15/14, the following was noted:</p> <p>a. an oxygen concentrator and a resident sleeping bed in Room D12 were observed plugged into a single power strip.</p> <p>b. a microwave oven was observed plugged into a power strip in the Business Office.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged power strips were utilized as a substitute for fixed wiring in the aforementioned locations.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p>	K030000	<p>immediately, in the presence of the surveyor. The microwave in the Business Office was unplugged from the power strip and plugged directly into the wall.</p> <p>2. All other power strips in the building have been observed and are being appropriately.</p> <p>3. Maintenance Director or his designee will inspect all power strips once a month to make sure they are being used appropriately.</p> <p>4. Results of these inspections will be submitted to the Quality Assurance Committee every month for a year.</p> <p>This plan of correction is to serve as Brown County Health and Living Community's credible allegation of compliance. Submission of this plan of correction</p>		

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	<p>Survey Date: 09/15/14</p> <p>Facility Number: 000479 Provider Number: 155487 AIM Number: 100290880</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brown County Health and Living Community was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. Building 03 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility consists of two sections: the original buildings, Building 01 and 02, were determined to be of Type V (111) construction and fully sprinklered. Building 03, the new Therapy Room and adjoining support rooms built in 2011 is of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has hard wired smoke detectors in</p>		<p>does not constitute an admission by Brown County Health and Living Community, or its management company, that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>		

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K030029 SS=E	<p>resident sleeping rooms E8 through E14 and has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 117 and had a census of 103 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage buildings which were not sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 7 doors serving hazardous areas such as fuel fired heater rooms were enclosed with a 3/4-hour fire rated door. This</p>	K030029	<p><u>K029</u> 1.45minute fire-rated door has been ordered to replace the 20 minute fire-rateddoor to the mechanical room. Door shouldarrive in 4 to 6 weeks and</p>	09/29/2014

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K030062 SS=C	<p>deficient practice could affect 10 residents, staff and visitors in the vicinity of the Mechanical Room by the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 09/15/14, the corridor door to the Mechanical Room by the Therapy Room had an affixed fire resistance rating label indicating a fire resistance rating of twenty minutes. The Mechanical Room by the Therapy Room contained two natural gas fired furnaces. Based on interview at the time of observation, the Maintenance Director stated the aforementioned Mechanical Room was part of the 2011 Therapy Room addition and acknowledged the fire resistance rating of the corridor door to the Mechanical Room by the Therapy Room was less than 3/4-hour.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p>		<p>will be installed immediately upon delivery.</p> <p>2. Allother doors leading to hazardous areas have been inspected and are in compliance.</p> <p>3. Maintenance Director or his designee will inspect doors to all hazardous areas and make sure they are in compliance at all times.</p> <p>4. Results of these inspections will be submitted to the Quality Assurance Committee every month for a year.</p>	

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	<p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:20 a.m. to 2:20 p.m. on 09/15/14, no spare sidewall sprinklers were located in the spare sprinkler cabinets in the sprinkler riser room. Sidewall sprinkler heads were observed installed in the Therapy Room. Based on interview at the time of observation, the</p>	K030062	<p><u>K062</u></p> <p>1. The appropriate number of spare sidewall sprinkler heads have been obtained from the Sprinkler System Contractor.</p> <p>2. There are an appropriate number of spare sprinkler heads on hand of each type and temperature for all sprinkler heads in the facility.</p> <p>3. Maintenance Director or his designee will inspect our supply of spare sprinkler heads to verify there we are in compliance with quantity and types of each sprinkler head.</p> <p>4. Results of these inspections will be submitted to the Quality Assurance Committee every month for a year.</p>	09/29/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155487	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED  09/15/2014
NAME OF PROVIDER OR SUPPLIER  BROWN COUNTY HEALTH AND LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 55 E WILLOW ST NASHVILLE, IN 47448		
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	Maintenance Director acknowledged no spare sidewall sprinklers were located on the premises or in the spare sprinkler cabinets.  3.1-19(b)				