STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVILLE HEALTHCARE CENTER	11049 SR 101 BROOKVILLE, IN 47012

(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
K010000	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: 04/17/13 Facility Number: 000550 Provider Number: 155480 AIM Number: 100286110 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Brookville 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 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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, in spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility	K010000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction 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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	has a capacity of 100 and had a census of 74 at the time of this visit. All areas where residents have customary access were sprinklered except the detached wooden smokers' sheds. All areas providing facility services were sprinklered except two fifteen by twenty four foot wooden storage garages and a wooden storage shed. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/22/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010015 SS=A	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 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 Based on observation and interview, the facility failed to ensure 1 of 88 rooms was provided with an interior finish with a flame spread rating of Class A, B or C in a sprinklered building. This deficient practice does not affect any residents based on the separation of the maintenance office from resident rooms in the 100 Hall, but could affect 1 maintenance supervisor. Findings include: Based on observation on 04/17/13 at 9:00 a.m. with the maintenance supervisor, the maintenance supervisor's office south wall had a section of drywall missing measuring four feet by seven feet on the south wall near the door. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m.	K010015	K015 Requires the facility to provide an interior finish with a flame spread of Class A, B, C in a sprinklered building.In the maintenance office, the dry wall was added to cover the four feet by seven feet area that was without. The maintenance supervisor audited the facility to ensure that no other areas in the facility was without needed drywall. The maintenance supervisor monthly will ensure that the facility has drywall in all areas that it needs to be present. (See Attachment A)	05/03/2013

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	3.1-19(b)			

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K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 88 room doors was provided with positive latching hardware suitable for keeping the door closed. This deficient practice could affect 11 residents who reside on the 200 Hall. Findings include: Based on observation on 04/17/13 at 11:40 a.m. with the maintenance supervisor, the latching device on the door to resident room 211 failed to latch into the door frame on three separate attempts. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on	K010018	K018 Requires the facility to provide room doors with positive latching hardware suitable for keeping the door closed.Room 211 door was repaired to ensure that it would latch. An audit of all facility doors occurred with no further findings. The maintenance supervisor will conduct monthly rounds to ensure that all doors continue to latch in the facility. (See attachment A)	05/03/2013

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	04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010021 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure once the fire alarm system is activated 4 of 4 smoke barrier door sets would remain self closing until the fire alarm system is returned to normal operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 04/17/13 during a test of the fire alarm system with the maintenance supervisor at 12:01 p.m., all smoke barrier door sets released initially with the fire alarm system but when the system was placed in silence mode and the doors were opened, the magnetic hold open devices engaged causing the smoke barrier doors to remain open instead of	K010021	K021 Requires the facility to ensure the fire alarm system is activated and smoke barrier doors set would remain closing until the fire alarm system is return to normal operations.The fire panel was repaired to ensure that the fire barrier doors would remain unlatched until the system was reset. The doors will be monitored for proper operation during the monthly fire drills. (See attachment A)	05/03/2013

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	self closing as required. This was verified by the maintenance supervisor at the time of fire alarm testing and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor doors to 2 of 6 rooms used to store hazardous soiled linen containers were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 74 residents who use the center nurses' station corridors and 2 residents who reside in resident room 320. Findings include: Based on observations during a tour of the center Nurses' Station Hall and the 300 Hall on 04/17/13 from 11:05 a.m. to 11:40 a.m. with the maintenance supervisor, the center Nurses' Station Hall shower room had three, 32 gallon soiled linen containers stored next to one another and resident room 320 had two,	K010029	K029 Requires the facility to ensure the corridor doors used to store hazardous soiled linen containers were provided with self closing devices which would cause the doors to automatically close and latch into the door frames.Self latching hardware was placed on all doors that were effected. The maintenance supervisor will monthly ensure that all areas that store hazardous soiled linen containers have self latching hardware attached to the door. (See attachment A)	05/03/2013

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	32 gallon soiled linen containers stored in the room and both doors were not provided with self closing devices. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010038 SS=F	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 Based on observation and interview, the facility failed to ensure 6 of 7 exit door electromagnetic locks remained unlocked while the fire alarm was activated and silenced. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 states, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided the following criteria are met. (d) Activation of the building fire protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire protective signaling system has been manually reset. This deficient practice affects all residents, staff and visitors. Findings include: Based on observations during a test of the fire alarm system on 04/17/13 with the maintenance supervisor at 12:01 p.m., the electromagnetic locks on the 100 Hall dining room, 100 Hall kitchen, 200 Hall physical therapy, 200 Hall, 300 Hall, and	K010038	K038 Requires the facility to ensure exit door electromagnetic locks remain unlocked while the fire alarm was activated and silenced. (See attachment A)A quote was received and approved from Superior Systems & Supply for the completion of the work to ensure all exit door electromagnetic locks reamain unlocked while the fire alarm is activated and silenced. The work is scheduled to be completed on or before May 17, 2013.(See attachment B)	05/17/2013

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	400 Hall exits released and unlocked when the fire alarm was activated, but reenergized and locked when the fire alarm was silenced but not reset. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to have 1 of 1 written health care occupancy fire safety plans that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on record review on 04/17/13 at 9:10 a.m. with the maintenance supervisor, the facility's fire safety plan labeled Fire Disaster Plan dated 01/2010 and revised 09/2012 did not contain information pertaining to the transmission of the fire alarm signal to the security monitoring service to the fire department. Furthermore, the plan did not address the	K010048	K048 Requires the facility to ensure the information pertaining to the transmission of the fire disaster plan contains information pertaining to the security monitoring service to the fire department. The Fire Disaster Plan has been revised to include the notification of the security monitoring system and the fire department upon activation of the alarm.(See attachment C)A plaque has been installed in the kitchen near the K-class fire extinguisher stating, "WARNING: In case of appliance fire, use this extinguisher after fixed suppression system has been actuated."	05/03/2013

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	use of the K-class fire extinguisher located in the kitchen in relationship to the use of the kitchen overhead extinguishing system. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 1. Based on record review and interview, the facility failed to ensure 1 of 4 quarterly fire alarm system inspection records was accurate in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm initiating devices, alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the facility's quarterly Periodic Fire Alarm Inspection & Testing Reports on 04/17/13 at 9:20 a.m., the report dated 03/12/13 indicated testing fifteen of thirty two photoelectric smoke detectors, seven of eight manual pull station boxes, one of one water flow	K010052	K052 Requires the facility to inspect the fire alarm system quarterly and accurately in accordance with the requirements of NFPA 72.Superior Systems who completes the fire alarm inspections reviewed all devices. Superior Systems will inspect all devices annually. The maintenance supervisor will review the inspection sheet to ensure all devices were reviewed annually. The smoke detector at the nurse's station by air duct was moved to the proper distance and all other smoke detectors were inspected for proper placement.	05/17/2013

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	sprinkler switch, eight of eight combined audible/visual alarm devices and ten of ten magnetic door holding devices. The second page of the report, which listed each devices' location and a pass or fail indicated ten smoke detectors with a check mark under tested and passed, five manual pull station boxes with a check mark under tested and passed, and two manual pull station boxes with a check mark under tested and passed. The second page of the report had a total of ten passed photoelectric smoke detectors which contradicted the first page number of fifteen total tested, a total of five manual pull station boxes, which contradicted the first page number of seven total tested, and the second page of the test report failed to indicate the test results either pass or fail for the eight combined audible/visual devices, ten magnetic door holding devices and the one sprinkler water flow switch. The inaccuracy of the 03/12/13 Periodic Fire Alarm Inspection & Testing Report was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 32			

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	photoelectric corridor and open use smoke detectors was located where airflow would not prevent the operation of the detector. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect any residents who use the center Nurses' Station Hall. Findings include: Based on observation on 04/17/13 at 11:55 a.m. with the maintenance supervisor, the center Nurses' Station hall smoke detector by the southeast corner of the nurses' station near the resident shower room was located one foot from a supply air duct. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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	155480		04/17/2013

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BROOKVILLE HEALTHCARE CENTER	11049 SR 101 BROOKVILLE, IN 47012

(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
K010056 SS=E	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			
	1. Based on observation and interview, the facility failed to provide sprinkler protection in 1 of 1 combustible structures used by 7 of 74 residents in accordance with LSC Section 19.1.6.2 and NFPA 13, 1999 Edition. This deficient practice could affect 7 of 74 residents who use the detached smokers building. Findings include: Based on observation with the maintenance supervisor on 04/17/13 at 12:10 p.m., the outdoor resident and staff smoking building, a separate, detached building of Type V (000) construction, lacked sprinkler protection. Based on interview at the time of observation, the maintenance supervisor acknowledged there are seven residents who smoke and	K010056	F056 Requires the facility to provide sprinkler protection for combustible structures used by residents in accordance with LSC and NFPA. The maintenance supervisor removed the north wall from the smoking building to make the structure a three walled building. Sprinklers in the lounge had the excess sprinklers removed. An audit was completed on all sprinklers to ensure that there is a six foot spacing. After completion of this project no further inspection needs to occur.	05/03/2013

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	use the nonsprinklered smoking building. This was confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b) 3.1-19(ff) 2. Based on observation and interview, the facility failed to ensure 1 of 1 lounges was provided with sprinklers with a minimum spacing of 6 feet. NFPA 13, The Standard for the Installation of Sprinklers at 4-6.3.4 requires sprinklers shall be spaced no less than 6 feet on center. This deficient practice could affect 28 residents who reside on the 100 Hall and could use the 100 Hall lounge. Findings include: Based on observation on 04/17/13 at 11:55 a.m. with the maintenance supervisor, the 100 Hall lounge had four sprinklers spaced between two feet and three feet apart. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:20 p.m. 3.1-19(b)			

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K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to replace 4 of 12 sprinklers in the kitchen covered in corrosion and rust. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 37 of 74 residents who use the 100 Hall main dining room, located adjacent to the kitchen and 13 residents who reside on the 100 Hall. Findings include: Based on observation at 11:05 a.m. with the maintenance supervisor on 04/17/13, four sprinklers in the kitchen along the corridor by the dishwashing machine were covered in green corrosion and brown rust. This was verified by the maintenance supervisor at the time of observation and confirmed by the	K010062	K062 Requires the facility to ensure that sprinklers are not covered with rust and corrosion and shall be inspected, tested and maintained in accordance with NFPA.Sprinklers had the rust and corrosion removed. All sprinklers were inspected for rust and corrosion. Escutcheons were replaced in 411, 404, 402, 310, 316, the employee break room and the boiler room. All escutcheons were audited for correct placement. The maintenance supervisor will monthly inspect all sprinklers for rust and corrosion and monthly ensure all escutcheons are in correct placement. (See attachment A)	05/03/2013

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	administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 8 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 2 residents who reside in resident room 411, 2 residents who reside in resident room 402, any of the 74 residents who use the center Nurses' Station Hall, 2 residents who reside in resident room 310, and 2 residents who reside in resident room 316. Findings include: Based on observations on 04/17/13 during a tour of the facility with the maintenance supervisor from 8:20 a.m. to 12:45 p.m., the following areas had sprinkler head escutcheons which were not flush to the ceiling leaving between a quarter inch and one half inch gap into the attic space above; resident room 411's bathroom, resident room 404 bed 2, two sprinklers by the coffee pot in the employee breakroom, two sprinklers in the center Nurses' Station Hall boiler room, resident room 310 bed 2, and resident room 316's bathroom. This was verified by the maintenance supervisor at the time of			

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	observations and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect 37 residents who use the 100 Hall main dining room and 13 residents who reside on the 100 Hall, where the kitchen is located. Findings include:	K010064	K064 Requires the facility to maintain K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10.The correct posting was placed by the K class portable fire extinguisher in the kitchen. the maintenance supervisor will check monthly to ensure the posting is placed by the K Class fire extinguisher in the kitchen. (See attachment A)	05/03/2013

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	Based on observation on 04/17/13 at 11:55 a.m. with the maintenance supervisor, the kitchen K-Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 3 areas where smoking was permitted used a metal self closing container for discarded smoking material and 2 of 3 areas where smoking was permitted utilized a noncombustible ashtray for discarded smoking material instead of the ground surface. This deficient practice could affect the 7 residents who smoke plus any residents in the facility if a fire occurred at one of the four areas where smoking was permitted. Findings include:	K010066	K066 Requires the facility to ensure to use a metal self closing container for discarded smoking material where smoking is permitted.All discarded smoking materials were removed from the area. Daily the maintenance supervisor will ensure all discarded smoking materials are properly disposed of and will place it on his daily preventative maintenance. (See attachment A)	05/03/2013

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	Based on observation on 04/17/13 during a tour of the facility with the maintenance supervisor from 8:20 a.m. to 12:45 p.m., the kitchen exit smoking location lacked a metal self closing container for discarded smoking material. Furthermore, the kitchen exit smoking location had approximately one hundred unlit discarded cigarette butts on the grass and pavement ground surface, and the 400 Hall outside exit smoking location had approximately fifty unlit cigarette butts on the grass and pavement ground surface. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 Based on observation and interview, the facility failed to ensure 3 of 88 rooms in the facility remained free of combustible decorations such as candles with wicks. This deficient practice affects 22 residents who reside on the 400 Hall, and any resident who use the center Nurses' Station Hall in the event a fire occurred from a lit candle. Findings include: Based on observations with the maintenance supervisor on 04/17/13 during a tour of the facility from 8:20 a.m. to 12:45 p.m., resident room 414 had two candles with wicks, resident room 409 had one candle with a wick, and the assistant director of nursing office had one candle with a wick. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)	K010073	K073 Requires the facility to ensure that it remains free of combustible decorations such as candles with wicks.All candles were removed from room 415, 409 and on the Assistant Director of Nurses office. The rest of the facility was audited to ensure no other candles were in the facility. Monthly the maintenance supervisor will audit the facility to ensure no candles are in the facility. (See attachment A)	05/03/2013

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K010075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for mobile soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 3 of 4 corridors. This deficient practice could affect 22 residents who reside on the 400 Hall, 11 residents who reside on the 200 Hall, and 13 residents who reside on the 100 Hall. Findings include: Based on observations on 04/17/13 during a tour of the facility with the maintenance supervisor from 8:20 a.m. to 12:45 p.m., the 400 Hall had three, thirty two gallon soiled linen containers stored in the corridor next to each other by the laundry room, the 200 Hall had two, thirty two gallon soiled linen containers stored in the corridor next to each other by resident room 209, and the 100 Hall had had two,	K010075	K075 Requires the facility to ensure that a capacity of 32 gallons for mobile soiled linen or trash receptacles was not exceeded within 64 square feet area. Soiled linen and trash receptacles will be stored in the shower room when not in use. The administrator or her designee will daily ensure that soiled linen and trash receptacles are stored in the shower room when not in use. (See attachment D)	05/03/2013

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	thirty two gallon soiled linen containers stored in the corridor next to each other by resident room 107. Furthermore, the soiled linen containers were observed at the same locations on 04/17/13 at 8:20 a.m. and 12:30 p.m. Based on an interview with the maintenance supervisor on 04/17/13 at 11:40 a.m., the soiled linen containers are stored on the 400 Hall, 200 Hall and 100 Hall on a permanent basis. This was verified by the maintenance supervisor at the time of observations and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on record review and interview, the facility failed to ensure 3 of 3 boiler/water heaters had inspection certificates that were current to ensure the water heaters were in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents in the facility. Findings include: Based on review of Boiler Inspection Records on 04/17/13 at 9:15 a.m. with the maintenance supervisor, the Boiler Inspection Certificates for the A O Smith hot water heater boiler, certificate # 3029964, expired on 08/11/12; the A O Smith hot water heater boiler, certificate #274816, expired on 06/11/12; and the A O Smith hot water heater, certificate #274815 expired on 06/11/12. This was verified by the maintenance supervisor at the time of record review and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)	K010130	K130 Requires the facility to ensure that boiler/water heaters had inspection certificates that were current to ensure the water heaters were safe operating condition.Boiler inspection certificate was obtained. When boiler inspections occur the maintenance will ensure that the inspection certificate is obtained within 30 days. The administrator will audit this after the inspection is complete. The discarded smoking materials were discarded properly. The maintenance supervisor will monitor daily to ensure that discarded smoking materials are discarded properly and will place it on the preventative maintenance log. (See attachment E)	05/03/2013

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	2. Based on observation and interview, the facility failed to ensure the location of 1 of 2 liquefied petroleum gas (LPG) containers was at least 25 feet away from a designated smoking area. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. LSC 8.4.3.1(3) requires the storage and handling of flammable liquids or gases to be in accordance with NFPA 58, 1998 Edition Liquefied Petroleum Gas Code. NFPA 58, Section 3-2.2.2 requires containers installed outside of buildings to be in accordance with Table 3-2.2.2. and Section 3-2.2.2(d) requires the distance measured in any direction from the point of discharge of a container pressure relief valve, the vent of a fixed maximum liquid level gauge on a container, or the installed location of the filling connection of a container to any exterior source of ignition, openings into direct-vent (sealed combustion system) appliances, or mechanical ventilation air intakes shall be in accordance with Table 3-2.2.2(d). Table 3-2.2.2(d) indicates			

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	the minimum distance between a LPG container with a water capacity of 501-2000 gallons and an exterior ignition source is 25 feet. This deficient practice could affect 7 resident, staff or visitors using the smoking area located outside the 400 Hall exit near the liquid petroleum gas container used for the kitchen cooking equipment. Findings include: Based on observation on 04/17/13 at 11:10 a.m. with the maintenance supervisor, the liquid petroleum gas container with a capacity of five hundred gallons, was located thirty seven feet from the 400 Hall outside smoking location. Furthermore, there were over one hundred unlit cigarette butts on the grass and asphalt ground surface on the west side of the metal container. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

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K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2			
	Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer locations was provided with mechanical ventilation. This deficient practice could affect 22 residents who reside on 400 Hall where the liquid oxygen storage room is located. Findings include: Based on observation on 04/17/13 at 9:55 a.m. with the maintenance supervisor, the 400 Hall liquid oxygen storage room where four full liquid oxygen containers were stored had a ceiling exhaust fan located in the center of the ceiling. Furthermore, the ceiling exhaust fan was not operational. Based on an interview with the maintenance supervisor on	K010143	K143 Requires the facility to ensure that oxygen/transfer locations are provided with mechanical ventilation. A new exhaust fan was installed and is working properly. The maintenance supervisor will daily ensure that the van is working properly and document this information on his preventative maintenance log.	05/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11049 SR 101 BROOKVILLE, IN 47012	

(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
	04/17/13 at 10:15 p.m., the liquid oxygen storage room is used for the storage of liquid oxygen and used as a transferring location by the nursing staff. The liquid oxygen storage room ceiling exhuast fan not being operational was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the exit conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11049 SR 101 BROOKVILLE, IN 47012	

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K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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 5 residents who receive therapy at one time, and 22 residents who reside on the 400 Hall near the employee lounge and the minimum data set office. Findings include: Based on observations on 04/17/13 during the tour from 8:20 a.m. to 12:45 p.m. with the maintenance supervisor, the minimum data set office, the employee lounge, and the therapy room each used a six outlet multiplug adapter plugged into a dual outlet electrical receptacle. This was verified by the maintenance supervisor at the time of observation, and confirmed by the administrator at the exit	K010147	K 147 Requires the facility to ensure non-fused multiplug adapters are not used as a substitute for fixed wiring.An audit was conducted in the facility and all multiplug adapters were removed from the facility. The maintenance supervisor will monthly ensure multiplugs are not being utilized in the facility. (See attachment A)	05/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER BROOKVILLE HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11049 SR 101 BROOKVILLE, IN 47012	

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	conference on 04/17/13 at 12:45 p.m. 3.1-19(b)			