STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155628		03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/11/16 Facility Number: 009569 Provider Number: 155628 AIM Number: 200139920 At this Life Safety Code survey, Briarwood Health and Rehabilitation 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 II (111) construction and was 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 smoke detectors hard wired to the fire alarm system in all resident sleeping rooms.	K 0000		

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

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

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	The facility has a capacity of 120 and had a census of 70 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing storage services which were each not sprinklered. Quality Review completed on 03/21/16 - DA			
K 0022 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 South Dining Room vestibule doors likely to be mistaken for a way of exit was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect 20 residents, staff and visitors in the South Dining Room. Findings include:	K 0022	K022 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providerof the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for	04/10/2016

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	Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, the South Dining Room has a vestibule in the path of egress to the outside of the building. The south door in the exit vestibule was bolted shut and could not be opened. The south door in the vestibule was not provided with a sign which identified the door as not an exit. Based on interview at the time of observation, the Housekeeping Manager stated only the east door in the exit vestibule is a facility exit, the south door was bolted shut and is not an exit and acknowledged the south door in the South Dining Room exit vestibule was not provided with a NO Exit sign. 3.1-19(b)		those residents identified: A "no exit" sign was installed on the east door in the vestibule. 2) How the facility identified other residents: All residents residing in facility have the potential to be affected. 3) Measures put into place/ System changes: A 100% audit off all doors in facility was done to ensure they have correct signs. 4) How the corrective actions will be monitored: All doors to be audited initially; then quarterly X3. Audits to be brought to safety committee meetings. Audits to be reviewed by Administrator/designee. 5) Completion Date: April 10, 2016	
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure openings through 1 of 17 smoke barrier walls were	K 0025	K025 The facility requests paper compliance for this citation. This Plan of Correction is	04/10/2016

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	protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 46 residents, staff and visitors. Findings include: Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, the one inch annular space surrounding each of two inch in diameter sprinkler pipes which penetrated the smoke barrier wall above the suspended ceiling above the corridor door set by Room 205 was not filled with a material to maintain the fire resistance rating of the smoke barrier wall. In addition, a three inch hole for the passage of twenty cables was also noted at the same smoke barrier wall location and was also not filled with a material to maintain the fire resistance rating of the smoke barrier wall. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the openings in the		the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providerof the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: The one inch annular space surrounding each two inch in diameter sprinkler pipes were filled with CP25WB material which has a 4 hour rating. The three inch hole for the passage of twenty cables were fill with CP25WB material which has a 4 hour rating. 2) How the facility identified other residents: All residents residing in facility have the potential to be affected. 3) Measures put into place/ System changes: Anytime a new penetration through a smoke barrier or fire rated wall the maintenance supervisor will ensure the CP25WB material is used. 4) How the corrective actions will be monitored: Further monitoring will be determined by Quality assurance. 5) April10, 2016	

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	aforementioned smoke barrier wall were not filled with a material to maintain the fire resistance rating of the smoke barrier wall. 3.1-19(b)			
K 0027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 8 sets of smoke barrier doors would close to form a smoke resistant barrier. Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect 38 residents, staff and visitors. Findings include: Based on observations with the	K 0027	K027 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:	04/10/2016

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	Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, the set of smoke barrier doors in the corridor by Room 301 and by Room 407 each swing in the same direction, are equipped with an astragal and a door closing coordinator but the door closing coordinator did not function when the smoke barrier door set was manually closed five times which did not ensure the door equipped with an astragal closes last and forms a smoke resistant barrier. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged each of the aforementioned smoke barrier door sets did not close because the door closing coordinator did not function and was prevented from closing and forming a smoke resistant barrier. 3.1-19(b)		A guide Wheel was place on the doors to ensure they will close correctly. Closures to be adjusted for speed and timing of door closing. 2) How the facility identified other residents: All residents residing in facility have the potential to be affected. 3) Measures put into place/ System changes: 100 % audit of all doors was conducted to insure all doors were in working order. 4) How the corrective actions will be monitored: Maintenance/designee will check 2rooms per week x 4 weeks then monthly to ensure all doors are closing correctly. 5) April 10, 2016	
K 0029 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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			

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	door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 7 hazardous areas such as central/bulk laundries larger than 100 square feet in size were separated from other areas by smoke resistant partitions. This deficient practice could affect two staff and visitors in the vicinity of the Laundry Room. Findings include: Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, a ten inch hole was noted in the ceiling of the Laundry Room in front of the natural gas fired dryers which exposed the deck of the ceiling above. Based on interview at the time of observation, the Maintenance Supervisor and Housekeeping Manager acknowledged the hole in the Laundry Room ceiling in front of the dryers did not separate this hazardous area from other spaces by smoke resistant partitions. 3.1-19(b)	K 0029	K 029 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: The hole in ceiling was patched with two layers of 5/8" dywall to create the 1 hour barrier. 2) How the facility identified other residents: Allresidents have the potential to be affected. 3) Measuresput into place/ System changes: Facility to use an audit tool placed into Tels preventative maintenance program to conduct random room checks. The Administrator/designee will review the audit reports monthly x 4 months then 2 timesYearly. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in QA monthly. Further monitoring will be	04/10/2016

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			determined by Quality assurance. 5) April 10, 2015	
K 0038 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 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 in the South Dining Room. Findings include: Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of	K 0038	K 038 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: A code was placed on the door and sign removed. 2) How the facility identified other residents: Allresidents have the potential to be affected. 3) Measures put into place/ System changes: A 100% audit was done on the doors to ensure they are all marked correctly and or coded. 4) How the corrective actions will be monitored: Maintenance/designee will check	04/10/2016

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	the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, the South Dining Room exit door into the south exit vestibule was marked as a facility exit, the exit door was magnetically locked and could be opened by entering a four digit code but the posted code did not release the exit door to open. Based on interview at the time of observation, the Maintenance Supervisor and Housekeeping Manager stated not all residents have a clinical diagnosis to be in a secure building and acknowledged the correct four digit code was not posted at the South Dining Room exit door into the south exit vestibule which would release the exit door to open. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an		3 doors weekly x 4 weeks then monthly thereafter. 5) April 10, 2015	

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NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205	

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	approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect 20 residents, staff and visitors in the South Dining Room.			

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	Findings include: Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, the South Dining Room exit door into the south exit vestibule was marked as a facility exit and was provided with signage stating the door could be opened in 15 seconds by pushing on the door release device but the exit door failed to open within 15 seconds when the door was pushed with the application of force three separate times. Based on interview at the time of observation, the Maintenance Supervisor and Housekeeping Manager stated the aforementioned exit is a facility exit, is equipped with signage stating the exit door could be opened in 15 seconds by pushing on the release device but acknowledged the exit door failed to open within 15 seconds when the door was pushed with the application of force three separate times. 3.1-19(b)			

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K 0046 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 1 of 1 battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr. duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Supervisor and Housekeeping Manager during from 8:45 a.m. to 11:00 a.m. on 03/11/16, documentation of monthly functional testing and annual testing for not less	K 0046	K 046 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Maintenance conducted 90 minute test on battery powered emergency light located at the emergency generator. Maintenance in-serviced on proper log documentation for Life-Safety code enforcement. 2) How the facility identified other residents: Allresidents have the potential to be affected. 3) Measuresput into place/ System changes: Facility to use an audit tool placed into Tels preventative maintenance program to conduct	04/10/2016

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	than 1 ½ -hr. duration for facility battery powered emergency lights for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility has one battery powered emergency light at the emergency generator location. Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, one facility battery powered light was located at the emergency generator. Based on interview at the time of record review and of the observation, the Maintenance Supervisor acknowledged documentation of monthly functional testing and annual testing for not less than 1 ½ -hr. duration for the most recent twelve month period for the battery powered emergency light located at the emergency generator was not available for review. 3.1-19(b)		battery backup lighting tests. The Administrator/designee will review the audit reports monthly x 4 months then 2 timesYearly. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in QA monthly. Further monitoring will be determined by Quality assurance. 5) April 10, 2015	
K 0050 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that			

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BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN 46205

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	drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			
	Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first, second and third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" and "Monthly Fire & Evacuation Alarm Drill Report" documentation with the Maintenance Supervisor and Housekeeping Manager during record review from 8:45 a.m. to 11:00 a.m. on 03/11/16, the following was noted: a. first shift fire drills conducted on 07/13/15, 10/14/15 and 01/26/16 were conducted at, respectively, 9:08 a.m., 9:14 a.m. and 9:00 a.m. b. second shift fire drills were conducted on 08/31/15, 11/24/15 and 02/26/16 were conducted at, respectively, 3:25 p.m., 3:57 p.m. and 3:30 p.m. c. third shift fire drills conducted on 06/28/15, 09/29/15 and 12/30/15 were	K 0050	K050 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Maintenance wasin serviced on the Fire Drill report andAlso, in-serviced on Tels task logs. Reviewed Life Safety Code Standards regarding Fire Drill Requirements in accordance with 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes:	04/10/2016

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	conducted at, respectively, 5:00 a.m., 4:55 a.m. and 4:00 a.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned fire drills on each shift were not conducted at unexpected times under varying conditions. 3.1-19(b)		The Administrator/designee will audit the Fire Drill reports monthly x 4 months then 2 times Yearly. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in QA monthly. Further monitoring will be determined by Quality assurance. 5) April 10, 2016	
K 0062 SS=F Bldg. 01	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 record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to	K 0062	K062 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. Maintenance Supervisor found the necessary documentation	04/10/2016

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	the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of VFP Fire Systems "Agreement & Report of Inspection" documentation dated 10/14/15 with the Maintenance Supervisor and Housekeeping Manager during record review from 8:45 a.m. to 11:00 a.m. on 03/11/16, it has been greater than 147 days since the most recent quarterly sprinkler inspection was conducted. Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, VFP Fire Systems had affixed a hanging tag to the sprinkler system riser stating water flow alarm testing of the sprinkler system was performed in April 2015 and July 2015. Based on interview at the time of record review and of the observation, the Maintenance Supervisor and Housekeeping stated additional sprinkler system inspection documentation after 10/14/15 was not available for review and acknowledged it has been greater than 120 days since the most recent quarterly sprinkler inspection has been conducted.		showing that we did have a quarterly sprinkler pipe inspection on 1/5/16. This keeps us in compliance. 2. A Sprinkler rated at 212 degrees was purchased. 3. The pendent sprinkler in the alcove area was replaced. 4. The cables that were affixed to an eight foot length of sprinkler pipe were detached. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes: 1. Facility to use an audit tool placed into Tels preventative maintenance program to conduct quarterly sprinkler pipe inspections. The Administrator/designee will review the audit reports quarterly, then 2 timesYearly. 2. A monthly audit will be conducted to ensure there are spare sprinklers for the automatic . Sprinkler system in on hand as required 3. Maintenance/ designee will audit 10 sprinkler heads to ensure no debris weekly x 4 weeks then monthly. 4. Maintenance/designee will ensure any time new cables are installed they are not affixed to any sprinkler pipe. 4) How the corrective actions will be monitored: The results of these audits will be	

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	3.1-19(b) 2. 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. Findings include: Based on observations with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, attic pendent sprinklers rated at 212 degrees Fahrenheit were		reviewed in QA monthly. Further monitoring will be determined by Quality assurance. 5) April 10, 2016	

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	installed in the attic area above the main lobby. Only one spare sprinkler rated at 212 degrees Fahrenheit was located on the premises in the spare sprinkler cabinet in the sprinkler riser room. Based on interview at the time of the observations, the Maintenance Supervisor and the Housekeeping Manager acknowledged only one spare attic sprinkler was located on the premises in the spare sprinkler cabinet. 3.1-19(b) 3. Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. 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 20 residents, staff and visitors. Findings include: Based on observation with the			

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	Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, the pendent sprinkler in the alcove area by Room 300 had white paint on the deflector. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned sprinkler had white paint on the deflector. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect two staff and visitors in the Mechanical Room. Findings include: Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m.			

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	on 03/11/16, three cables were affixed to an eight foot length of sprinkler pipe in the Mechanical Room housing the main fire panel for the facility. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned sprinkler pipe location was being used to support nonsystem components. 3.1-19(b)			
K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire	K 0069	K069 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: 1. Maintenance Supervisor found the necessary documentation showing that we did have a	04/10/2016

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	exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on review of Preventive Maintenance Services (PMS) "Invoice" documentation dated 10/16/15 with the Maintenance Supervisor and Housekeeping Manager during record review from 8:45 a.m. to 11:00 a.m. on 03/11/16, documentation of semiannual kitchen exhaust systems inspection six months prior to 10/16/15 was not available for review. Based on observation with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, a sticker affixed to the kitchen range hood indicated the most recent hood inspection was performed by PMS in October 2015. No other kitchen exhaust systems		Kitchen exhaust hood cleaning on 4/24/15. This keeps us in compliance. New Maintenance Supervisor was instructed how to find necessary information from corporate office in the event documentation is lost. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes: 1. Facility to use an audit tool placed into Tels preventative maintenance program to conduct exhaust hood cleanings/examinations. The Administrator/designee will review the audit reports semi-annually. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in QA monthly. Further monitoring will be determined by Quality assurance. 5) April 10, 2016	

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	inspection documentation prior to October 2015 was available for review. Based on interview at the time of record review and of the observation, the Maintenance Supervisor acknowledged documentation of semiannual kitchen exhaust systems inspection six months prior to October 2015 was not available for review. 3.1-19(b)			
K 0074 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3			

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	o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. Based on record review, observation and interview; the facility failed to ensure window valences in resident sleeping rooms in 2 of 8 smoke compartments were flame resistant. This deficient practice could affect 46 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor and Housekeeping Manager during a tour of the facility from 11:00 a.m. to 1:00 p.m. on 03/11/16, window valences in resident sleeping rooms 201, 202 and 204 through 211 had no affixed documentation stating each valence was inherently flame retardant. Based on record review with the Maintenance Supervisor and Housekeeping Manager during from 8:45 a.m. to 11:00 a.m. on 03/11/16, resident room window valence flame resistant documentation was not available for review. Based on interview at the time of record review and of the observations, the Maintenance Supervisor and Housekeeping Manager stated resident room valences are not treated with a flame retardant material and acknowledged resident room window	K 0074	K074 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: All valences that were not inherently flame retardant were removed. 2) How the facility identified other residents: All residents residing in facility have the potential to be affected. 3) Measures put into place/ System changes: Maintenance/designee will ensure that any newly added material items will be treated with Flame retardant. 4) How the corrective actions will be monitored: Will be reviewed in QA Monthly. 5) April 10, 2016	04/10/2016

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	valence flame resistant documentation was not available for review. 3.1-19(b)			
K 0144 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) 1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 1 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent	K 0144	K144 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. 1) Immediate actions taken for those residents identified: Maintenance wasin-serviced on the Weekly generator logs andAlso, in-serviced on Tels task logs. Reviewed Life Safety Code Standards regarding Generator inspections in accordance with NFPA 99 and NFPA 110.3-4.4.1 and 8-4.2 (NFPA99), Chapter 6	04/10/2016

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	of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Record" documentation with the Maintenance Supervisor and Housekeeping Manager during record review from 8:45 a.m. to 11:00 a.m. on 03/11/16, documentation of monthly load testing for the emergency generator for February 2016 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged monthly load testing documentation for the emergency generator for February 2016 was not available for review. 3.1-19(b)		(NFPA 110). Maintenance Supervisor immediately conducted generator inspections and has continued doing so every week 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes: Facility to use an audit tool placed into Tels preventative maintenance program to conduct generator & battery inspections on a weekly basis. The Administrator/designee will review the audit reports monthly x 4 months then 2 timesYearly. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in QA monthly. Further monitoring will be determined by Quality assurance. 5) April 10, 2016	

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NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205	

(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
	2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 6 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Record" documentation with the Maintenance Supervisor and Housekeeping Manager during record review from 8:45 a.m. to 11:00 a.m. on 03/11/16, documentation of weekly			

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	155628		03/11/2016

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	inspections of the starting batteries for the emergency generator for the weeks of 02/01/16 through 03/07/16 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the aforementioned six week period was not available for review. 3.1-19(b)			