

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 06/08/2015
--	---	--	---

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
--------------------	--	---------------	---	----------------------

K 0000 Bldg. 01	<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: 06/08/15</p> <p>Facility Number: 000550 Provider Number: 155480 AIM Number: 100286110</p> <p>At this Life Safety Code survey, Brookville Healthcare Center was found in substantial 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.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of</p>	K 0000	<p>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. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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.

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 06/08/2015
--	---	--	---

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
K 0062 SS=C Bldg. 01	<p>59 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility had one detached wooden storage garage which was not sprinkled.</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. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected every five years as required by NFPA 25, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 10-2.2. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 06/08/15 at 9:00 a.m., there was no documentation to indicate an internal inspection of the dry sprinkler system had been conducted in the past five years. Based on a review of the dry sprinkler riser on 06/08/15 at 9:45</p>	K 0062	<p>K0062 Requires the facility to ensure automatic dry sprinkler piping systems are inspected every five years.1. The Director of Maintenance contacted Superior Systems to schedule an internal inspection of the automatic dry sprinkler piping system.2. The inspection of the automatic dry sprinkler piping system was added to the preventative maintenance log to ensure the inspection is completed every 5 years.3. The Director of Maintenance was educated on ensuring the need to have the automatic dry sprinkler piping system inspected every five years.4. The Director of Maintenance will add the inspection of the automatic dry sprinkler piping system every five years to his preventative maintenance log and will be</p>	07/03/2015

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 06/08/2015
--	---	--	---

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
	a.m. with the maintenance supervisor, the dry sprinkler riser, located in the main mechanical room, had a date of the last internal pipe inspection of 09/02/2008, which was a period exceeding five years. The lack of a five year internal pipe inspection was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 06/08/15 at 12:25 p.m. 3.1-19(b)		reviewed at the quarterly quality assurance meeting to ensure continued compliance.	