

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155761	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2014
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NAME OF PROVIDER OR SUPPLIER BROWNSBURG MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2 E TILDEN BROWNSBURG, IN 46112
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 10/23/14</p> <p>Facility Number: 011367 Provider Number: 155761 AIM Number: 200851590</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brownsburg Meadows 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 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident rooms. The facility has a</p>	K010000	<p>The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVIEW on or after 11/18/14.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K010018 SS=E	<p>capacity of 160 and had a census of 89 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 sets of double leaf corridor doors on Administrative hall could latch independently into their door frame. This deficient practice could affect 12 residents on 100 hall as well as visitors and staff.</p>	K010018	<p>K018 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? On 10/31/14 the latches on the family room door were replaced with positive latching hardware. 2. How other residents having the</p>	11/18/2014			

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K010051 SS=F	<p>Findings include:</p> <p>Based on observation on 10/23/14 at 12:30 p.m. the double door set leading into the Family room on Administrative hall, adjacent to 100 hall required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame:</p> <p>Based on interview on 10/23/14 concurrent with the observation, it was acknowledged by the Maintenance Supervisor, the aforementioned set of corridor doors would not latch independently into the door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm</p>		<p>potential to be affected by the same deficient practice will be identified and what correction actions will be taken? All residents have the potential to be affected. On 10/31/14 the latches on the family room door were replaced with positive latching hardware. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? All other doors protecting corridor openings constructed to resist the passage of smoke have been examined and found to have positive latching hardware 4. How the corrective actions will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place?</p> <p>The Maintenance Director will be responsible for completing the daily, weekly, monthly, quarterly, and annual preventative maintenance program to assure compliance with all applicable regulations. Any issues found will be brought to the Executive Director and forwarded to the QA Committee.</p>				

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	<p>initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 10/23/14 at 2:10 p.m., with the Maintenance Supervisor the door leading to the fire alarm system circuit breaker located in the north Mechanical room was impaired and could not be opened and closed without great difficulty so it was kept open for ease of operation thereby accessible to anyone. In addition, the Mechanical</p>	K010051	<p>K051 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The doors leading to the north mechanical room have been ordered and are being replaced. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction actions will be taken? All other residents have the potential to be affected. The doors leading to the north mechanical room have been ordered and are being replaced. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The door will now remain locked and will only be assessable to authorized personnel. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance</p>	11/18/2014

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K010130 SS=E	<p>room could only be accessed from the outside of the building thereby making it accessible to the public as well. Also, the breaker for the fire alarm panel inside this Mechanical room was marked FA next to the breaker in black. Based on interview on 10/23/14 at 2:15 p.m. with the Maintenance Supervisor it was acknowledged the fire alarm circuit breaker was not correctly identified and the panel box or door leading into the Mechanical room must be locked.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling metal fire doors were in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 6 residents observed in the Main</p>	K010130	<p>program will be put into place? The Maintenance Director will be responsible for completing the daily, weekly, monthly, quarterly, and annual preventative maintenance program to assure compliance with all applicable regulations. Any issues found will be brought to the Executive Director and forwarded to the QA Committee.</p> <p>K130 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The annual inspection for the rolling fire door in the kitchen was completed on 10/24/14. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what correction actions will be taken? All other residents have the potential to be affected. The annual inspection for the rolling fire door in the kitchen was completed on 10/24/14. 3. What measures will be put into place or what systemic changes will be made</p>	11/18/2014			

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	<p>dining room adjacent to the Kitchen as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 10/23/14 at 2:28 p.m. with the Maintenance Supervisor, there was a metal rolling fire door protecting the opening from the kitchen to the Main dining room which had an attached inspection tag indicating the last inspection was 06/06/13. Based on interview on 10/23/14 at 2:30 p.m. with the Maintenance Supervisor and Inspection vendor there was no additional documentation of an annual inspection or test to check for proper operation and full closure since 06/06/13.</p> <p>3.1-19(b)</p>		<p>to ensure that the deficient practice does not recur? The annual inspection of this rolling door has now been contracted with the same company that completes our other inspections and will be done on an annual basis. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur (i.e., what quality assurance program will be put into place? The Maintenance Director will be responsible for completing the daily, weekly, monthly, quarterly, and annual preventative maintenance program to assure compliance with all applicable regulations. Any issues found will be brought to the Executive Director and forwarded to the QA Committee.</p>				