

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE HAVEN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303
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(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	<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: 08/18/14</p> <p>Facility Number: 000311 Provider Number: 15E064 AIM Number: 100285520</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brookside Haven Health Care Center was found not in compliance with Requirements for Participation in 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a</p>	K010000	K-000This Plan of Correction is prepared and executed because it is required by the provisions of the State and Federal regulations, and not because Brookside Haven agrees with the allegations and citations listed on this statement of deficiencies. This Plan of Correction shall operate as Brookside Haven's written credible allegation of Compliance.	

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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K010029 SS=E	<p>capacity of 42 and had a census of 42 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/21/14.</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 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</p>			

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	<p>Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas such as the kitchen would self close. This deficiency could affect 7 residents observed in the Main dining room which is adjacent to the kitchen, as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 08/18/14 at 12:35 p.m. with the Maintenance Supervisor, the Dutch door which separates the kitchen from the adjacent dining room which opens up to Center hall was not equipped with a self closing device on the door. Based on interview on 08/18/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned kitchen door did not self close because of the absence of a self closing device on the door.</p> <p>3.1-19(b)</p>	K010029	<p>K-029</p> <p>1.) Maintenance supervisor immediately purchased a door closer and contacted Superior Systems to install releasing magnetic mechanism on Dutch door from dietary to main dining room to ensure self-closing devise works properly during any signal transmission during regular operations.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Maintenance supervisor will monitor the self closing devise on the Dutch Door during monthly scheduled fire drills to ensure self closing devise works properly during any signal transmission and will document on the (Report Of Monthly Fire Drill Sheet), and shall report to the administrator any malfunction with the closing mechanism.</p> <p>4.) Maintenance supervisor will monitor daily for placement of self-closing mechanism and will monitor monthly for proper functioning during signal transmission and will report to the Quality Assurance Committee (QAA) for 6 months to ensure compliance and will follow any recommendations.</p>	09/05/2014			

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills on all shifts for 1 of 4 quarters for the past 12 months. This deficient practice affects all residents in the facility including staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill records on 08/18/14 at 2:15 p.m. with the Maintenance Supervisor, a fire drill report for the first shift of the first quarter of 2014 was not available for review.</p> <p>Based on interview on 08/18/14 at 2:17 p.m. with the Maintenance Supervisor, it was acknowledged the fire drill for the aforementioned shift of the first quarter of 2014 had not been done.</p> <p>3.1-19(b)</p>	K010050	<p>5.) Date Completed: 09/05/14</p> <p>K-050</p> <p>1.) Maintenance supervisor and HFA reviewed the fire drill in-service book to ensure monthly fire drills are being performed and documented.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Maintenance supervisor and HFA will monitor monthly fire drill and both shall sign off on each monthly fire drill as completed to ensure on-going compliance. Maintenance supervisor shall perform a fire drill each shift per quarter.</p> <p>4.) Maintenance supervisor shall report to the Quality Assurance Committee (QAA) during regular scheduled meeting and follow any</p>	09/05/2014

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	3.1-51(c)		recommendation. 5.) Date Completed: 09/05/2014		