

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY RD 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: 06/25/14</p> <p>Facility Number: 000113 Provider Number: 155206 AIM Number: 100287670</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brownsburg Health Care 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.</p> <p>This one story facility was determined to be of Type III (200) 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 operated smoke detectors in</p>	K010000	<p>SUBMISSION OF THIS PLAN OF CORRECTION SHALL NOT CONSTITUTE OR BE CONSTRUED AS AN ADMISSION BY BROWNSBURG HEALTH CARE CENTER THAT THE ALLEGATIONS CONTAINED IN THE SURVEY REPORT ARE ACCURATE. THIS PROVIDER RESPECTFULLY REQUESTS THAT THE 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION OF COMPLIANCE AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVISIT ON OR AFTER JULY 25, 2014.</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.

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K010038 SS=E	<p>all resident rooms. The facility has a 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. The facility has two detached storage buildings which were not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/08/14.</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 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 exit access was arranged so 2 of 2 Patio exit access doors were not equipped with 2 locking devices on the doors. Section 19.2.2.2.5 states means of egress are permitted to be locked, but only one locking device shall</p>	K010038	There were no residents identified as being affected by this deficiency. All facility residents have the potential to be affected. No residents were affected. On June 30, 2014, the Maintenance Director removed the door knob locks from the Patio doors from the dining room and patient room	06/30/2014

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K010051 SS=C	<p>be permitted on each door. This deficient practice could affect 16 residents on Wing 8 using the Patio area as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 06/25/14 during the tour between 1:33 p.m. and 2:06 p.m. with the Maintenance Supervisor, the east and west exit access doors to the Patio adjacent to the Dining room and Wing 8 had a door knob lock and a deadbolt lock on each door leading into the Patio. Based on interview on 06/25/14 concurrent with the observations, it was acknowledged by the Maintenance Supervisor there were two locking devices on each of the Patio doors leading out of the Dining room and Wing 8.</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, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic</p>		<p>on Wing 8. The Maintenance Director will monitor all doors monthly to ensure doors are not double locked. Any concerns will be addressed by the facility Quality Assurance Committe.</p>	

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	<p>detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. 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 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>1. 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 06/25/14 at 1:56 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in Riser room # 2 on Service hall lacked full identification. Inside the panel cover to the circuit breakers was a breaker labeled in black "fire." Based on interview on 06/25/14 at 1:57 p.m. with</p>	K010051	There were no residents identified as being affected by this deficiency. Any residents, visitors or staff in the dining room near Wing 6 North have the potential to be affected. No residents, visitors or staff were affected. On 6/26/2014, a sign labeled with red marking that says Fire Alarm Circuit Control was placed inside the panel cover to the circuit breakers. The Maintenance Director will monitor the circuit breaker panel monthly to ensure it remains in place. The smoke detector located in the Director of Nursing office above a ceiling fan was removed by the Maintenance Director on 6/25/2014.	06/26/2014

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	<p>the Maintenance Supervisor, it was acknowledged the circuit breaker was not labeled with red marking to say Fire Alarm Circuit Control.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors on Wing 6 north was installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 5 residents in the Dining room on wing 6 north as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/25/14 at 2:55 p.m. with the Maintenance Supervisor, the smoke detector in the Director of Nurse's (DON) office located adjacent to the Dining room on Wing 6 north was directly above a ceiling fan which was in operation at the time of observation.</p> <p>Based on interview on 06/25/14 at 2:56 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detector was installed above an operating ceiling fan in the DON's office</p>			

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K010056 SS=F	<p>which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p> <p>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 Based on observation and interview, the facility failed to ensure 1 of 1 steel armover sprinkler pipes observed was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler,</p>	K010056	There were no residents identified as being affected by this deficiency. All residents, visitors and staff have the potential to be affected. No residents, visitors or staff were affected. On July 10, 2014, the Maintenance Director installed a support hanger to the pipe armover over the washers in the laundry room. All sprinkler pipes will be inspected annually	07/10/2014

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K010062 SS=E	<p>sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building as well as staff or visitors if the sprinkler system required repair.</p> <p>Findings include:</p> <p>Based on observation on 06/25/14 at 3:15 p.m. with the Maintenance Supervisor, in the Laundry room on Service hall there was a metal sprinkler pipe armover above the washers which measured twenty nine inches in length and was unsupported.</p> <p>Based on interview on 06/25/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported.</p> <p>3.1-19(b)</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 observation and interview, the facility failed to ensure 1 of 1 sprinkler</p>	K010062	<p>by the Sprinkler Alarm Company to ensure that all pipes are supported appropriately.</p> <p>There were no residents identified as being affected by this</p>	07/24/2014			

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K010064 SS=E	<p>heads observed in the Rehabilitation room closet were clean. 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 the 20 residents on Ivy court as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/25/14 at 2:30 p.m. with the Maintenance Director, the sprinkler head located in the Rehabilitation room closet off of Center hall was loaded with drywall spackle. Based on interview on 06/25/14 at 2:31 p.m. with the Maintenance Supervisor, it was confirmed the sprinkler head in aforementioned location was loaded with drywall spackle.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on observations and interview, the facility failed to ensure 1 of 39 portable ABC class fire extinguisher</p>	K010064	<p>deficiency. Twenty residents at the front nursing station (Ivy Court) as well as visitors and staff have the potential of being affected. No residents, visitors or staff were affected. The Maintenance Director will install a new sprinkler head in the Rehabilitation room closet to replace the head with drywall spackle on it. The Maintenance Director will inspect all sprinkler heads in the facility to ensure they are clear of any drywall spackle and replace any as they are needed.</p> <p>There were no residents identified as being affected by this deficiency. Twenty eight residents on Wing 5, visitors and</p>	07/24/2014			

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	<p>pressure gauge readings was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 28 residents on Wing 5 adjacent to the attached garage as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/25/14 at 3:00 p.m. with the Maintenance Supervisor, the gauge on the ABC Class portable fire extinguisher in the attached Maintenance garage showed the extinguisher to be discharged and another fire extinguisher was not available to replace it. Based on interview on 06/25/14 at 3:01 p.m. with the Maintenance Supervisor, it was agreed the gauge reading was not in the normal operating range and they did not have a replacement available.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 2</p>		<p>staff have the potential to be affected. No residents, visitors or staff were affected. The Maintenance Director replaced the fire extinguisher in the maintenance garage on 6/26, 2014. A placard that states activate fire protection system prior to using Class K fire extinguisher will be placed near the Class K extinguisher in the kitchen. The Maintenance Director will monitor all fire extinguishers monthly to ensure they are in working order. The Maintenance Director will check monthly to ensure placard remains near the Class K fire extinguisher in the kitchen.</p>				

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	<p>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 any residents using the Main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 06/25/14 at 2:28 p.m. with the Maintenance Supervisor, there was a K class extinguisher conspicuously placed next to the entry door to the kitchen, but lacked a placard. Based on interview on 06/25/14 at 02:30 p.m. with the Maintenance Supervisor it</p>			

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K010066 SS=D	<p>was acknowledged the K class portable fire extinguisher was not provided with a placard and was unaware one was needed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied</p>			

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	<p>are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure 2 of 2 areas where smoking was permitted were provided with metal containers with self closing covers into which cigarette butts could be extinguished. This deficient practice could affect 3 staff observed under the gazebo adjacent to Wing 2 and the smoking area adjacent to the Maintenance garage where residents and visitors were also allowed to smoke.</p> <p>Findings include:</p> <p>Based on observations on 06/25/14 during the tour between 2:00 p.m. and 3:00 p.m. with the Maintenance Supervisor, the designated smoking areas under the gazebo adjacent to Wing 2 and the Maintenance garage area were provided with long neck plastic containers without self closing covers to deposit cigarette butts. Based on record review on 06/25/14 at 3:35 p.m. with the Maintenance Supervisor, the smoking policy indicated cigarettes would be deposited into a metal container with a self closing cover. Based on interview on 06/25/14 concurrent with each observation, it was acknowledged by the Maintenance Supervisor that metal containers with self closing covers were</p>	K010066	There were no residents identified as having been affected by this deficiency. All residents, visitors and staff have the potential to be affected. No residents, visitors or staff were affected. Facility policy does not allow residents or visitors to smoke any where on facility premises. Metal containers with self-closing covers will be placed in the two facility staff smoking areas by the Maintenance Director. The Maintenance Director will monitor smoking areas weekly to ensure the metal containers with self-closing covers are in the staff smoking areas.	07/24/2014

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K010130 SS=E	<p>not provided in the gazebo or the smoking area next to the Maintenance garage.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, interview and record review; the facility failed to ensure the location of 1 of 1 liquefied petroleum gas (LPG) containers was at least 5 feet away from a designated smoking area. LSC 19.1.1.3 states health facilities shall be maintained and operated to minimize the possibility of a fire emergency. 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) specifies 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</p>	K010130	<p>There were no residents identified as having been affected by this deficiency. Residents, visitors and staff near the south patio smoking area have the potential to be affected. No residents, visitors or staff were affected. Facility policy does not permit smoking by residents or visitors any where on facility premises. The LP tank for the barbecue grill was removed from the staff smoking area by the Maintenance Director on 6/26/2014. The tank will not be used or stored within 5 feet of staff smoking areas. The Maintenance Director will check the location of the LP tank weekly to ensure it is not within 5 feet of a staff smoking area.</p>	06/26/2014

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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
	<p>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 the minimum distance between a portable LPG container replaced on a cylinder exchange basis and an exterior ignition source is 5 feet. This deficient practice could affect any resident near the smoking area as well as staff or visitors using the smoking area outside the facility near the south patio.</p> <p>Findings include:</p> <p>Based on observation on 06/25/14 at 2:15 p.m. with the Maintenance Supervisor, the sixteen lb portable propane tank used to provide fuel for the outdoor grill was within 5 feet of the gazebo where smoking was permitted. Based on interview on 06/25/14 at 2:20 p.m. with the Maintenance Supervisor, it was acknowledged this area is used for residents, visitors and staff to smoke and the portable propane tank still contained fuel and was adjacent to the resident smoking area. Furthermore, the Maintenance Supervisor was unaware the portable propane tank needed to be five feet away from an ignition source. Based on review of the smoking policy on 06/25/14 at 2:45 p.m. with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2014
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K010147 SS=D	<p>Maintenance Supervisor, the resident smoking area was not to be near a combustible gas source.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 22 surge protectors observed in resident rooms, including extension cords, nonfused extension cords and multiplug adapters were not used as a substitute for fixed wiring. 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 2 residents in room # 410 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/25/14 at 1:11 p.m. with the Maintenance Supervisor, a surge protector was used to provide power to medical equipment such as a</p>	K010147	No residents were identified as having been affected by this deficiency. Two residents in room 410, visitors and staff have the potential to be affected. No residents, visitors or staff were affected. The surge protector was removed from room 410 by the Maintenance Director on 7/15/2014 and medical equipment plugged directly into wall outlets. The Maintenance Director will check resident rooms monthly to ensure medical equipment is plugged directly into electrical wall outlets.	07/24/2014

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	<p>feeding pump in resident room # 410 instead of directly plugging the medical equipment into a wall outlet. Based on interview on 06/25/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor, a surge protector was used for the aforementioned medical device.</p> <p>3.1-19(b)</p>				