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 05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

(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: 05/21/15 Facility Number: 000113 Provider Number: 155206 AIM Number: 100287670 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. This one story facility was determined to be of Type III (200) construction and 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 battery operated smoke detectors installed in all resident sleeping rooms. The facility has	K 0000	SUBMISSON OF THIS PLAN OF CORRECTION SHALL NOT CONSTITUTE OR BE CONSTRUED AS AN ADMISSION BY BROWNBURG 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 JUNE 20, 2015.	

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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	a capacity of 160 and had a census of 91 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached storage buildings which were not sprinklered.			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the electrical panel room by Room 502. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:20 p.m. on 05/21/15, the escutcheon plate was	K 0025	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 May 21, 2015, the Maintenance Director replaced the missing escutcheon plate for the automatic sprinkler and patched the one and a half inch hole in the ceiling. He also replaced the light fixture so that it would not impede the escutcheon plate for the automatic sprinkler. The Maintenance Director or Designee will perform weekly inspection for the first three months and monthly thereafter to ensure compliance	06/20/2015

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	missing for the automatic sprinkler located next to a newly installed light fixture in the electrical panel room by Room 502 which left a one and a half inch hole in the ceiling and exposed the attic above. In addition, the light fixture was installed such that it would impede proper installation of an escutcheon for the sprinkler. Based on interview at the time of observation, the Maintenance Director stated the light fixture should be moved or replaced to ensure proper escutcheon placement and acknowledged an escutcheon for the aforementioned automatic sprinkler location was missing which left a one and a half inch hole in the ceiling and exposed the attic above. 3.1-19(b)		by checking all sprinklers and light fixture placement throughout the facility. The Maintenance Director will report all negative findings to the QA Committee monthly for review.	
K 0029 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure corridor doors to	K 0029	There were no residents identified as being affected by this deficiency. All facility residents	06/20/2015

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	1 of 15 hazardous areas such as trash collection rooms were provided with self closing devices. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the biohazard storage room by Room 510. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:20 p.m. on 05/21/15, the corridor entry door to the biohazard storage room by Room 510 was not equipped with a self closing device. The biohazard storage room by Room 510 contained two red bag biohazard waste collection bags which were each partially filled with biohazard waste. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the aforementioned trash collection room was not equipped with a self closing device. 3.1-19(b)		have the potential to be affected. No residents were affected. On May 21, 2015, the Maintenance Director added a self-closing devise to the biohazard storage roomdoor. The Maintenance Director or Designee will perform weekly inspections for the first three months and monthly thereafter, to ensure that all storage room doors are equipped with working self-closing devices. The Maintenance Director will report all negative findings to the QA Committee monthly for review.	
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			

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	1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of SafeCare's "Service Call Report" documentation during record review with the Maintenance Director from 9:15 a.m. to 10:40 a.m. on 05/21/15, an internal pipe inspection conducted on 09/29/14 for the facility's sprinkler system stated "I.P. was done on 09/28/09 and we recommend system be flushed. System has not been flushed. We still recommend system be flushed. Send flush quote". Based on interview at the time of record review, the Maintenance Director stated flushing of the sprinkler system on or after 09/29/14 has not been performed due to scheduling issues and acknowledged dry sprinkler system flushing has not been performed or scheduled on or after 09/29/14.	K 0062	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 May 21, 2015, the Maintenance Director began obtaining competitive bids to flush the internal pipes for the fire suppression system. The facility is asking for an extension of the deficiency correction date and has submitted a temporary waiver form. Completion of the flush of the fire suppression system will take approximately three weeks once approval has been given and work has begun. The Maintenance Director will report the ongoing process to the monthly QA Committee and will cease upon completion of the flush.	10/31/2015

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads was maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the electrical panel room by Room 502. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:20 p.m. on 05/21/15, the escutcheon plate was missing for the automatic sprinkler located next to a newly installed light fixture in the electrical panel room by Room 502 which left a one and a half inch hole in the ceiling and exposed the attic above. In addition, the light fixture was installed such that it would impede proper installation of an escutcheon for the sprinkler. Based on interview at the time of observation, the Maintenance Director stated the light fixture should be moved or replaced to ensure proper escutcheon placement and acknowledged an escutcheon for the aforementioned			

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	automatic sprinkler location was missing which left a one and a half inch hole in the ceiling and exposed the attic above. 3.1-19(b)			
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. 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 3 residents, staff and visitors in the vicinity of the Pantry by the 800 Hall soiled utility room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 10:40 a.m. to 1:20 p.m. on 05/21/15, a microwave oven was plugged into a power strip in the Pantry by the 800 Hall soiled utility room. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned	K 0147	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 May 21, 2015, the Maintenance Director relocated the microwave oven to an alternative location within the pantry and removed the power strip. The Maintenance Director or Designee will conduct weekly inspection for the first three months and monthly thereafter to ensure complianceby checking all pantries and utility rooms for the incorrect use of power strips. The Maintenance Director will report all negative findings to the QA Committee monthly for review.	06/20/2015

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	location. 3.1-19(b)			