

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  02/10/2012
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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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K0000	<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: 02/10/12</p> <p>Facility Number: 000113 Provider Number: 155206 AIM Number: 100287670</p> <p>Surveyor: Mark Caraher, 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 fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and all areas not separated from the corridor. The facility has a capacity of</p>	K0000	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 or reflect accurately the provisions of care and service to the residents of Brownsburg Health Care Center.	
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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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	<p>160 and had a census of 125 at the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/16/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
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K0038 SS=E	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 1 of 14 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock which requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects any resident, staff or visitor if exiting the facility at the Main Dining Room exit.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:35 a.m. to 2:20 p.m. on 02/10/12, all exit doors were magnetically locked and could be opened by entering a four digit code, but the code was not posted at the Main Dining Room exit. Based on</p>			K0038	<p>There were no residents identified as being affected by this deficiency. A sign was posted at the Main Dining Room exit door with the four digit code. All facility residents have the potential to be affected. No residents were affected. Maintenance staff will check facility exit doors at least weekly to see that the exit code signs remain posted. Any identified concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan until resolution occurs.</p>		03/11/2012

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	<p>interview at the time of observation, the Director of Maintenance stated the Main Dining Room wall was recently painted and the facility forgot to repost the code at the exit. The Director of Maintenance acknowledged the Main Dining Room exit door's four digit code was not posted at the Main Dining Room exit.</p> <p>3.1-19(b)</p>			
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K0048 SS=E	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Disaster Preparedness Plan: Fire Emergency" during record review with the Director of Maintenance from 10:25 a.m. to 11:35 a.m. on 02/10/12, the fire safety plan did not address the use of ABC type fire extinguishers and the K class fire</p>	K0048	<p>There were no residents identified as being affected by this deficiency. The facility Disaster Preparedness Plan: Fire Emergency plan has been updated to include the training of the kitchen staff to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher. All facility residents have the potential to be affected. No residents were affected. The fire safety plan has been updated to include: "in the case of a hood fire, pull the hood fire suppression system first before using the K class fire extinguisher." The Dietary Manager and/or the Maintenance Director will be responsible to see that each new kitchen employee is trained on the fire plan for the kitchen. The Assistant Director of Nursing will check employee records upon hire to see that the updated fire safety plan has been given to new employees and training is documented. Any identified concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan until resolution occurs.</p>	03/11/2012			

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	<p>extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.</p> <p>3.1-19(b)</p>			
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K0062 SS=D	<p>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 replace 1 of 1 sprinklers in the Housekeeping Office which is corroded. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 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 one staff member in the Housekeeping Office in the service corridor.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance during a tour of the facility from 11:35 a.m. to 2:20 p.m. on 02/10/12, the automatic sprinkler in the Housekeeping office was green and had become corroded. Based on interview at the time of observation, the Director of Maintenance acknowledged the sprinkler in the Housekeeping Office in the service corridor is corroded.</p>	K0062	There were no residents identified as being affected by this deficiency. The automatic sprinkler head in the Housekeeping office has been replaced with a new head. All facility residents have the potential to be affected. No residents were affected. The Maintenance staff will be responsible to inspect all sprinkler heads in the facility at least quarterly to identify any that need to be replaced. Any identified concerns will be addressed in the monthly Quality Assurance Meeting via a written action plan until resolution occurs.	03/11/2012			

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