

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 06/03/2013
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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: 06/03/13</p> <p>Facility Number: 011367 Provider Number: 155761 AIM Number: 200851590</p> <p>Surveyor: Mark Caraher, 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 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 smoke detectors hard wired to the fire alarm system</p>	K010000	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 June 5, 2013.	

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>installed in all resident sleeping rooms. The facility has a capacity of 136 and a census of 128.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/05/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure openings in 2 of 11 smoke barriers were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any resident, staff or visitor in the vicinity of the smoke barrier wall near the entrance to the Therapy Gym.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 12:50 p.m. to 2:50 p.m. on</p>	K010025	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The two areas in the attic were filled were fire stop to meet code 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 residents have the potential to be affected. The two areas in the attic were filled were fire stop to meet code. 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 Maintenance Director completed rounds of the entire facility to ensure no other breaks in the smoke barrier existed. 4. How the corrective actions will be monitored to ensure the deficient practice</p>	06/05/2013	

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	<p>06/03/13, the smoke barrier wall in the attic above the corridor door set to the Assisted Living Wing from the 400 Hall had three, four inch in diameter open ended pipes passing through the wall. The three pipes had a total of twenty cables passing through the pipe openings in the wall which were each not firestopped. In addition, the smoke barrier wall in the attic above the corridor door set in the 200 Hall had two, four inch in diameter open ended pipes passing through the wall. The two pipes had a total of twenty cables passing through the pipe openings in the wall which were each not firestopped.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke barrier openings were each not firestopped.</p> <p>3.1-19(b)</p>		<p>will not recur (i.e., what quality assurance program will be put into place? To ensure compliance, the Main/ Designee is responsible for completion of Life Safety CQI tool, weekly x 4 weeks, bimonthly x 2 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p>		