

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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
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: 01/23/13</p> <p>Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Exceptional Living Center of Brazil 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 facility was determined to be of Type V (000) construction and was fully sprinklered. The facility</p>	K0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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>has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 105 and had a census of 94 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing a general maintenance storage facility which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/30/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
K0025 SS=E	<p>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</p> <p>Based on observation and interview, the facility failed to ensure openings through 1 of 7 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 could affect visitors, staff and 20 or more residents in the two center main hall smoke compartments.</p>	K0025	<p>This Plan of Correction constitutes Exceptional Living Center of Brazil written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was sited correctly. This plan is submitted to meet requirements established by state and federal law.</p> <p>K-025 NFPA 101 Life Safety Code Standard: Smoke barriers are constructed to provide at least a half hour fire resistant rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall.</p> <p>1) The Maintenance Director/Designee immediately checked the opening for the passage of cables through the attic smoke barrier wall and the second penetration that the seal had come loose to create a small gap located</p>	02/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 01/23/13 at 11:20 a.m., a three inch opening for the passage of cables through the smoke barrier wall above the lay in ceiling near room 126 was unsealed leaving a gap of 1/2 to 3/4 inches. A second penetration had been sealed but the seal had not held leaving a one inch gap at the top of the pipe penetrating the smoke barrier. The maintenance director agreed at the time of observation, the gaps should have been sealed.</p> <p>3.1-19(b)</p>		<p>near room 126. The Maintenance Director/Designee sealed the opening for the passage of cables and the attic smoke barrier wall identified near room 126 with approved caulking. (SEE ATTACHEMNT A) Completed on: 01/25/2013.</p> <p>2) All residents have the potential to be affected by the alleged deficiency. The Maintenance Director/Designee will check the attic smoke barrier walls for proper sealing per state and federal guidelines. (SEE ATTACHMENT B) Completion by 02/15/2013.</p> <p>3) The Maintenance Director/Designee will check attic smoke barrier walls for proper sealing 1 time per week for 4 weeks and then quarterly/as needed basis. (SEE ATTACHEMNT B).</p> <p>4) The Maintenance Director/Designee will review the Attic Smoke Barrier Construction Zone form with the Executive Director on a monthly basis and then quarterly/ as needed basis. (SEE ATTACHMENT B).</p> <p>Compliance date: 02/21/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
K0048 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 availability of 1 of 1 K-class fire extinguishers and its use in conjunction with the overhead hood system in the written fire plan. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>The plan should include each type of fire extinguisher available and any special requirement for their usage.</p> <p>This deficient practice could affect kitchen staff, and any visitors and 20 or more residents in the main dining room.</p>	K0048	<p><u>K048</u> NFPA 101 Life Safety Code Standard. A written plan for the protection of all residents and fortheir evacuation in event of an emergency.</p> <ol style="list-style-type: none"> 1) The executive Director/Designee immediately copied revised facility written fire plan which includes the required identification of the availability of the K-Class fire extinguisher. The revised fire plan was placed in all facility Disaster Plan Manuals to ensure compliance with state and federal guidelines. (SEE ATTACHMENT C). Completed on : 02/08/2013 2) All residents, kitchen staff and any visitors in the main dining room have the potential to be affected by the alleged deficiency. 3) The Maintenance Director/ Designee will review facility Fire Plan on an as needed basis to ensure that the required written information is updated when received by facility and then the revised facility Fire Plan will be copied and placed in all copies of the Facility Disaster Plan Manuals. The Maintenance Director/Designee in-serviced staff on revised facility Fire Plan. (SEE ATTACHMENT D) Facility Fire Plan 	02/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>Findings include:</p> <p>Based on review of the Fire Procedure with the executive director and maintenance director on 01/23/13 at 3:20 p.m., the plan did not identify the availability of the K-class fire extinguisher located in the kitchen and its relationship with the use of the kitchen overhead extinguishing system. The executive director acknowledged at the time of record review, these elements were not addressed in the plan, although inservices and training specific to the K-class fire extinguisher were documented.</p> <p>3.1-19(b)</p>		<p>will be reviewed and a copy given to new employees during orientation. (SEE ATTACHEMNT C).</p> <p>4) The Maintenance Director/Designee will review any changes to the facility Fire Plan on an as needed basis with the facility Executive Director to ensure the most current facility Fire Plan is copied and placed in all the facility Disaster Plan Manuals and staff education is provided to ensure compliance with all state and federal guidelines. (SEE ATTACHMENT C).</p> <p>5) Compliance date: 02/21/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013	
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL				STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834			
(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			
K0050 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 ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the maintenance director and executive director on 01/23/13 at 3:15 p.m., there was no record of a second shift fire drill for the first quarter during 2012. The maintenance director acknowledged fire drill records were not complete and said he had provided all fire drill documentation.</p>	K0050	<p><u>K050</u> NFPA 101 Life Safety Code Standard: Fire Drills are held at unexpected times under varying conditions, at least quarterly on each shift.</p> <p>1) The Maintenance Director/Designee will conduct required Fire Drills at unexpected times, under varying conditions, at least quarterly on each shift and document them on facility Fire Drill Log (SEE ATTACHEMENT E)</p> <p>2) All residents, staff and visitors have the potential to be affected by the alleged deficiency</p> <p>3) The Maintenance Director/Designee will conduct Fire Drills at least quarterly on each shift and document on facility Fire Drill Log (SEE ATTACHMENT E). To ensure compliance with state and federal guidelines.</p> <p>4) The Maintenance Director/Designee will review</p>	02/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
	3.1-9(b) 3.1-51(c)		<p>facility Fire Drill Log with the Executive Director on a monthly basis for 3 months and then on an as needed basis. (SEE ATTACHEMNT E)</p> <p>5) Compliance date: 02/21/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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
K0068 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with makeup combustion air from the outside. NFPA 54, 1999 Edition of the National Fuel Gas Code, Section 6.4.3(b) requires for the provision for makeup air for Type 2 clothes dryers. A Type 2 clothes dryer is defined as "not designed for use in an individual family living environment." This deficient practice could affect visitors, staff, and 4 residents in the same smoke compartment receiving treatment in physical therapy.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 01/23/13 at 11:50 a.m., the laundry room had three, gas fueled dryers with no fresh air intake. The maintenance director acknowledged the three gas fueled dryers did not have a fresh</p>	K0068	<p>K068 NFPA 101 Life safety Code Standard: Combustion and ventilation air. 1) The Maintenance Director/Designee contacted Heating /Air Conditioning contractor on 01/24/2013 to evaluate and supply a proposal to complete needed installation of the alleged required makeup combustion air from the outside for facility's 3 of 3 Type 2 clothes dryers. 2) Any residents, staff and visitors in the same smoke compartment of the facility have the potential to be affected by the alleged deficiency. 3) The Executive Director/Designee will submit request for approval to have required equipment installed to provide the 3 of 3 facility Type 2 clothes dryers with makeup combustion air for the outside per state and federal guidelines. 4) The Maintenance Director/Designee will monitor the installation of required equipment and will inform the Executive Director on a routine basis of the installation process of the required equipment in order to meet state and federal guidelines. 5) Compliance date: 02/21/2013</p>	02/21/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834
---	---

(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
	air intake. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013	
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL				STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834			
(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			
K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 2 electric circuit breaker boxes observe in the Earl's Cottage corridor was maintained in a safe operating condition. LSC 19.1.1.3 requires facilities shall be maintained and operated to minimize the possibility of a fire emergency. This deficient practice could affect visitors, staff and 20 or more residents on Earl's Cottage.</p> <p>Findings include:</p> <p>Based on observation on 01/23/13 at 10:55 a.m. with the executive director and the maintenance director, the circuit breaker panel for electrical wiring on the Earl's Cottage unit was examined. The circuits on the left side of the box were warmer than normal to touch. Circuit 17 was too hot to touch for more than a moment. The maintenance director acknowledge at the time of observation, the temperature of these circuits was not normal.</p>	K0130	<p>K130NFPA 101 Life safety Code Standard: Other LSC deficiency not on 2786.</p> <p>1) <u>A.</u>The Maintenance Director/Designee immediately examined the alleged deficient circuit number 17 on the left side of the circuit breaker panel located on Earle's Village. The circuit breaker number 17 was turned to the off position at this time to ensure that the circuit number 17 would not get to hot per alleged deficiency. (Completed 01/23/2013). The facility contacted a Licensed Electrician to check the alleged deficient circuit number 17. Please see contracted Electrician documented out come. (ATTACHMENT F). Based on the outcome of the inspection circuit number 17 was switched to the on position. (Completed 02/04/2013)</p> <p><u>B.</u> The Maintenance Director/Designee contacted Danny Nickolson of Cincinnati Life Insurance Company requesting inspection of the 1 of 1 service water heater (SWH) on the 200 hall. Dates Danny Nicholson was contacted: 09/10/2012, 09/11/2012, 09/25 /2012 and 11/05/2012-on this date the Maintenance Director was informed by Dan Nicholson that the</p>	02/21/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013	
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL				STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834			
(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>3.1-19(b)</p> <p>2. Based on observation, record review, and interview; the facility failed to ensure 1 of 1 service water heaters (SWH) on the 200 hall had a certificate of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects visitors, staff and 30 residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation on 01/23/13 at 11:35 a.m. with the executive director and maintenance director, the 200 hall service water heater had no certificate of inspection posted. The maintenance director said at the time of observation, the water heater was installed 09/02/12 and inspectors were notified to come. The maintenance director said at the time of observation, the water heater had not been inspected. He provided documentation he had last called to request an</p>		<p>State Inspections were running 2 months behind. Danny Nicholson was contacted again on 01/28/2013 and 01/29/2013. Danny Nicholson stated that the Sate Inspector would be onsite within the next 2 weeks. (SEE ATTACMENT G). The Maintenance Director contacted Steve Pauley-Inspector-Boiler and Pressure Vessel Safety Division of Fire and Building Safety Indiana Department of Homeland Security to inquire about facility request for inspection of effected 1of 1 water heater. Maintenance Director spoke with Mr. Pauley. Mr. Pauley confirmed facility's past requests and supply written documentation to support the past requests.(SEE ATTACHEMNT H) Per attachment H Mr. Pauley is to inspect the 1 o1 affected water heaters on 02/18/2013.</p> <p>2) <u>A</u>)All residents, staff and visitors have the potential to be affected by the alleged deficiency. Facility Maintenance Director/Designee will check alleged circuit breaker number 17 on a weekly basis to ensure the breaker stays normal temperature per state and federal guidelines. On February 4 , 2013 the facility had a contracted Electrician to inspect the alleged deficient breaker number 17. (SEE ATTACHMENT F).</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
	inspection on 11/05/12. 3.1-19(b)		<p>B) All residents on the 200 hall, staff and visitors could be affected by the alleged deficiency. Facility Maintenance Supervisor will continue to make contact Mr. Pauley with Indiana Department of Homeland Security to ensure that the required inspection is completed of effected 1 of 1 water heater to meet state and federal guidelines.</p> <p>-</p> <p>3) A)The Maintenance Director/Designee will check alleged circuit breaker number 17 on a weekly basis to ensure the breaker stays normal to touch to meet state and federal guidelines. Facility Maintenance Director/Designee will document the outcome on Preventative Maintenance Form (SEE ATTACHEMNET I).</p> <p>-</p> <p>B) The Maintenance Director/Designee will contact Danny Nicholson with Cincinnati Insurance Company when a new water heater is installed to request the required inspection of water heater to meet state and federal guidelines. The Maintenance Director/Designee will complete documentation each time contact is made to ensure that the facility is making every attempt for a new water heater to be inspected per state and federal guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>4. A) The Maintenance Director /Designee will review the Preventative Maintenance Form with the Executive Director on a monthly /as needed basis (SEE ATTACHMENT I)</p> <p>B) The Maintenance Director/Designee will review documentation of communication with (Danny Nichols of Cincinnati Insurance Company) with the Executive Director on a weekly/as needed basis to meet state and federal guidelines.</p> <p>5) Compliance date: 02/21/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
K0143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 rooms where liquid oxygen transferring takes place was provided with continuous mechanical ventilation to the outside. This deficient practice affects visitors, staff and 4 residents undergoing physical therapy treatment in the same smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 01/23/13 at 11:55 a.m., the</p>	K0143	<p>K143 NFPA 101 Life Safety Code Standard Transferring of oxygen is in an area mechanically ventilated, sprinkle red, and has ceramic or concrete flooring.</p> <p>1) The Maintenance Director/Designee immediately checked the 1 of 1 rooms where liquid oxygen transferring takes place and continuous mechanical ventilation to the outside occurs per state and federal guidelines. The Maintenance Director/Designee secured switch that controls the mechanical vent so that the switch cannot be switched to the off position to ensure that the mechanical vent functions continuously to provide mechanical ventilation to the outside. (Completed 01/23/2013)</p>	02/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>oxygen transfer and storage room was identified by signage on the door. When the door was opened to the room the mechanical vent was not running. The executive director then flipped a switch in the room and the vent could be heard running. She acknowledged at the time of observation, turning the vent off did not provide the continuous mechanical ventilation required for the oxygen transfilling room.</p> <p>3.1-19(b)</p>		<p>2) Residents, staff and visitors that would be present within this area smoke compartment could be affected by the alleged deficiency. The Maintenance Director/Designee secured switch that controls the mechanical vent so that the switch cannot be switched to the off position to ensure that the mechanical vent functions continuously to provide mechanical ventilation to the outside. (Completed 01/23/2013</p> <p>3) The Maintenance Director/Designee will inspect the mechanical vent and switch on a weekly/as needed basis. The outcome will be documented on the Oxygen Preventative Maintenance Task Form to ensure that the mechanical vent functions continuously and is in compliance with state and federal guidelines. (SEE ATTACHEMNT J)</p> <p>4) The Maintenance Director/Designee will review the Oxygen Preventative Maintenance Task Form with the Executive Director on a monthly/as needed basis to ensure compliance with state and federal guidelines.</p> <p>5) Compliance date: 02/21/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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	
K0147 SS=E	<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>1. Based on observation and interview, the facility failed to ensure multitap adapters, extension cords and power strip extension cords were not used as substitutes for fixed wiring in 3 of 7 smoke compartments. NFPA 70, the National Electrical Code, 1999 Edition, 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 visitors, staff, and 30 or more residents in the physical therapy, and 100 and 200 hall smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 01/23/13 between 10:00 a.m. and 1:30 p.m.:</p> <p>a. Multi tap outlet adapters were used to provide power to a refrigerator and television in room</p>	K0147	<p>K147 NFPA 10 Life Safety Code Standard. Electrical wiring and equipment is in accordance with NFPA70, National Electrical Code 9.1.2.</p> <p>1 -1. A) The Maintenance Director /Designee examined all effected rooms that could be effected by the alleged deficiency that utilized multi type adapters in rooms 106,104, 2019 and 133. The Maintenance Director/Designee removed all multi type adapters to ensure compliance of state and federal guidelines. (Completed on 01/30/2013)</p> <p>B) The Maintenance Director/Designee examined all effected rooms that could be effected by the alleged deficiency that utilized power strips in rooms 104, 107, 131, 205, the nourishment room near the nurses' station and the unit managers office in addition to Resident rooms 107, 122. Power strips located under and beside residents beds in rooms 104, 107 and 133. The Maintenance Director/Designee removed all refrigerators, and or medical equipment from all power strips that were being utilized to provide power to alleged deficient practice. (Completed on 02/07/2013).</p> <p>C) The Maintenance</p>	02/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013	
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL				STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834			
(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>106, a refrigerator in room 104, a television in room 219, and television, clock and phone equipment in room 133;</p> <p>b. Power strips provided power in rooms 104, 107, 131 and 205, the nourishment room near the nurses station, and the unit manager's office for refrigerators. Power strips were in use for medical equipment in physical therapy and resident rooms for nebulizers in rooms 107 and 122. Power strips were located under and beside resident beds in rooms 104, 107 and 133, and in the unit managers office.</p> <p>c. An extension cord powered a fan and radio in the laundry. The maintenance acknowledged the use of power strips, an extension cord and multitap adapters at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes observed in the Earl's Cottage shower room was maintained in a safe operating condition. LSC 19.5.1 requires</p>		<p>Director/Designee examined the facility laundry room that could be effected by the alleged deficiency. The Maintenance Director/Designee removed the extension cord located in facility laundry room (Completed 01/30/2013)</p> <p>1- 2. Residents , staff and visitors that would be present in the Physical Therapy, 100 and 200 halls smoke compartments could be effected by the alleged deficiency. The Maintenance Director/Designee examined and made corrections to all areas/items identified by alleged deficiency. (Completed 02/07/2013).</p> <p>1- 3. The Maintenance Director/Designee will inspect all residents rooms and other alleged areas on monthly/on as needed basis to ensure compliance with state and federal guidelines. The Maintenance Director/Designee will document inspection of all listed areas on Facility Electrical Outlet Proper Application Form (See attachment K). To ensure compliance with state and federal guidelines.(Completed 02/07/2013).</p> <p>1- 4. The Maintenance Director/Designee will review the Facility Electrical Outlet Proper Application Form (See attachment K) with the Executive Director on a monthly/ as needed basis to ensure</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could visitors, staff and 20 or more residents on the Earl's Cottage hall.</p> <p>Findings include:</p> <p>Based on observation with the executive director and maintenance director on 01/23/13 at 11:00 a.m., a junction box in a storage alcove in the Earl's Cottage hall was open and the wiring within exposed. The maintenance director acknowledge at the time of observation, the cover should have been closed on the box.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure wet locations for resident rooms and the shower room in 1</p>		<p>compliance with state and federal guidelines.</p> <p>2-1. The Maintenance Director/Designee examined alleged effected 1of1 electrical junction boxes in Earle's Village shower room to correct stated alleged deficiency. The Maintenance Director/Designee repaired electrical junction box by replacing a missing bottom screw. (Completed 01/23/2013)</p> <p>2-2. The alleged deficiency could effect residents, staff and visitors in Earle's Village.</p> <p>2-3. The Maintenance Director/Designee will examine in-house junction boxes for utility equipment services on a monthly basis for 3 months and then at least quarterly / an as needed basis to ensure compliance with state and federal guidelines. Maintenance Director/Designee will document inspection of utility equipment services junction boxes on the Building Utility /Junction Box Inspection Form. (SEE ATTACHEMNT K).</p> <p>2-4. The Maintenance Director/designee will review the Building Utility /Junction Box Inspection Form with the Executive Director on a monthly/as needed basis.</p> <p>3-1. The Maintenance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>of 7 smoke compartments were provided with GFCI (ground-fault circuit interrupter) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects visitors, staff and 20 or more residents on the Earl's Cottage hall.</p> <p>Findings include:</p> <p>Based on observations with the executive director and maintenance director on 01/23/13 between 10:00 a.m. and 2:00 p.m., electrical outlets in the Earl's Cottage resident rooms and common shower room were</p>		<p>Director/Designee checked all effected outlets that we identified in the alleged deficiency. The Maintenance Director and Assistant individually tested electrical outlets in Earle's Village residents rooms and common shower room where electrical outlets were located less than 3 feet from electrical outlets. All residents rooms, common shower area were found to be protected by GFCI breaker in the distribution panels. Each appropriate panel was identified and labeled with GFCI number and individual rooms and common shower room that the GFCI breaker protects. (Completed 01/29/2013).</p> <p>3-2. Residents, staff and visitors in Earle's Village have the potential to be effected by the alleged deficiency. The Maintenance Director and Assistant individually tested electrical outlets in Earle's Village residents rooms and common shower room where electrical outlets were located less than 3 feet from electrical outlets. All residents rooms, common shower area were found to be protected by GFCI breaker in the distribution panels. Each appropriate panel was identified and labeled with GFCI number and individual rooms and common shower room that the GFCI breaker protects. (Completed 01/29/2013).</p> <p>3-3. The Maintenance Director/Designee checked all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155503	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTER OF BRAZIL			STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN 47834		
(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>located less than three feet from electrical outlets. The outlets were not provided with GFCI (ground fault circuit interrupter) to prevent electric shock. The electrical panels were checked with the maintenance director for GFCI circuit breakers. GFCI circuit breakers were found but not identified and he could not be certain which outlets were connected to them.</p> <p>3.1-19(b)</p>		<p>effected outlets to ensure compliance with state and federal guidelines. The Maintenance Director/ Designee identified and labeled each appropriate panel with GFCI breaker number and individual rooms, common shower area that GFCI protects. (Completed 01/29/2013). There are no other areas within the facility that were effected by the alleged deficiency. (Completed 01/29/2013).</p> <p>3-4. The facility Maintenance Director identified and demonstrated to the Executive Director changes made within Circuit Breaker Box to ensure compliance with state and federal guidelines. Completed 01/29/2013). The Maintenance Director/Designee will review any changes for GFCI outlets with Executive Director on an as needed basis to ensure compliance with state and federal guidelines. Compliance date: 02/21/2013</p>		