

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 12/01/2011
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NAME OF PROVIDER OR SUPPLIER EXCEPTIONAL LIVING CENTERS OF BRAZIL	STREET ADDRESS, CITY, STATE, ZIP CODE 501 S MURPHY AVE BRAZIL, IN47834
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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: 12/01/11</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 Centers 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 one story story facility was determined to be of Type V (000)</p>	K0000	<p>Correction and specific corrective actions are prepared and/or executed solely because provisions of Federal and/or State Laws. Exceptional Living Centers of Brazil desires this Plan of Correction to be considered the facility's allegation of Compliance. Preparation and. or execution of the Plan of Correction in general, or any corrective action set forth herein, in particular, does not constitute an admission or agreement by Exceptional Living Centers of Brazil of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Compliance is effective. 12-23-2011</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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K0018 SS=E	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 105 and had a census of 94 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/06/11.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to</p>	K0018	K-018NFPA 101 Life Safety Code Standard Doors protecting corridor openings are provided with means	12/23/2011	

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	<p>ensure doors protecting corridor openings had no impediment to closing and would latch in 1 of 6 smoke compartments. This deficient practice affects staff, visitors and more than 12 residents in the east center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 12/01/11 at 12:20 p.m., two doors protected corridor openings from the assisted dining room: the west door which failed to latch into the door frame twice when tested twice with the maintenance director and the east door which could not be closed into the door frame. On two attempts made by the maintenance director, the door stuck in the door frame. It could not be completely closed and took full force with two hands to open the door. The maintenance director said at the time of observations, he was unaware the doors were not operating correctly.</p>		<p>suitable for keeping the door closed.</p> <p>1. The Maintenance Director/Designee immediately checked both doors identified in the alleged deficiency. There were no residents directly within the alleged area. The Maintenance Director/Designee made adjustments to the Assist Dining Room East and West Corridor Doors to ensure that both doors closed and opened per requirements. (See Attachment A) 12/02/2011</p> <p>2. Maintenance Director/Designee will check all protected corridor door openings to ensure that all are functional per state and federal guidelines. Any doors in need of repair facility employee will immediately make the repair. (See attachment B) 12/16/2011</p> <p>3. The Maintenance Director/Designee will check the the Assist Dining Room East and West Corridor Doors M-F for 4 weeks and then weekly/PRN to ensure compliance with state and federal regulations. (See Attachment A)</p> <p>4. The Maintenance Director/Designee will review the Preventative Maintenance form with the Executive Director on a monthly/PRN basis.</p>		

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K0038 SS=E	<p>3.1-19(b)</p> <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 1 of 2 locked exit doors on Earls Village unlocked upon entry of a code into the keypad adjacent to the door. LSC 19.2.2.2.5 requires doors allowed to be locked in a means of egress shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. This deficient practice affects staff, visitors, and 30 residents in Earls Village.</p> <p>Findings include:</p> <p>Based on observation of the north exit from Earls Village with the maintenance director and administrator on 12/01/11 at 1:30 p.m., the north exit door was equipped with a magnetic door</p>	K0038	<p>Compliance 12/23/2011</p> <p>K-038 NFPA 101 Life Safety Code Standard Exit access is arranged so that exits readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. The Maintenance Director/Designee immediately checked the exit door identified in the alleged deficiency. The Maintenance Director/Designee made adjustments to the to the exit door keypad adjacent to the door to ensure that the door closed and opened per requirements. Door at this time functioned properly. Maintenance Supervisor/Designee contacted vendor to inform of alleged deficiency and requested vendor come to facility and check affected door for proper functioning. Completed on 12/02/2011. Door was functioning properly. (See Attachment C)</p> <p>2. Maintenance Director/Designee will check all locked exit doors to ensure that all are functional per state and federal guidelines. Any doors in need of repair facility employee will</p>	12/23/2011	

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K0048 SS=F	<p>lock designed to release upon activation of the fire alarm, a power outage and a code entered into the keypad adjacent to the exit door. The maintenance director attempted to open the door twice using the code. The door did not open. The door could be opened upon activation of the fire alarm. The administrator and maintenance director agreed at the time of observations, the locking mechanism and keypad override were malfunctioning.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to include the use of fire extinguishers in the written plan for the protection of 94 of 94 residents in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide</p>	K0048	<p>immediately make the repair. (See attachment B) 12/16/2011</p> <p>3. The Maintenance Director/Designee will check the exit door identified in the alleged deficiency M-F for 4 weeks and then weekly/PRN to ensure compliance with state and federal regulations. (See Attachment A and Attachment B)</p> <p>4. The Maintenance Director/Designee will review the Preventative Maintenance form with the Executive Director on a monthly/PRN basis. Compliance 12/23/2011</p> <p>K-048 NFPA 101 Life Safety Code Standard There is a written plan of protection for all patients and for their evacuation in the event of an emergency.</p> <p>1. The Maintenance Director/Designee immediately contacted contracted vendor (USA Automatic Sprinkler) to inform of alleged deficiency and requested placement of</p>	12/23/2011	

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	<p>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>This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the facility's undated written Fire Plan on 12/01/11 at 11:45 a.m. with the maintenance director and administrator, the fire plan did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. In addition a disaster procedure guidelines manual referred to extinguishing a "small" fire which the administrator and maintenance director agreed, staff were not trained to assess.</p>		<p>K class fire extinguisher for placement in facility kitchen Completed on 12/06/2011 (See attachment D). Executive Director/Designee will make necessary additions to correct alleged deficiency to facility disaster and fire procedure to comply with state and federal regulation. (See attachment E and G).</p> <p>2. The Maintenance Director/Designee checked all fire extinguishers to ensure that all meet state and federal guidelines per alleged deficiency. (See attachment F). Executive Director/Designee will in-service staff on changes made to facility disaster and fire procedure to correct alleged deficiency. Executive Director/Designee will in-service staff on operating instructions of fire extinguishers. (See attachment E and G) Compliance (12/23/2011).</p> <p>3. The Maintenance Director/Designee will monitor all fire extinguishers on a monthly/prn basis through the facility Monthly Preventative Maintenance Program to ensure compliance of alleged deficiency. (See attachment F) Executive Director/Designee will provide and review facility fire procedure, and fire extinguisher operating instructions during employee orientation.(See attachments E and G)</p> <p>4. The Maintenance Director/Designee will review with the Executive Director on a monthly/prn basis the Preventative Maintenance</p>		

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K0144 SS=F	<p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary</p>	K0144	<p>Program to ensure.</p> <p>The Executive Director/Designee will review employee records on a monthly/prn basis for completion of facility fire procedure, and fire extinguisher operating instructions during employee orientation.</p> <p>Compliance 12/23/2011</p> <p>K-144 NFPA 101 Life Safety Code Standard</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1 NFPA 110, 199 edition 5-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building.</p> <p>1. The Maintenance Director/Designee immediately checked for the required Emergency Generator remote manual stop station per the alleged deficiency. Maintenance Supervisor immediately contacted an appropriate vendor to have a remote stop station installed. Installation completed on 12/14/2011. (See attachment H)</p> <p>2. The facility has one</p>	12/23/2011

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	<p>Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on interview on 12/01/11 at 1:20 p.m. with the maintenance director and administrator, the emergency generator was installed after 2003. The maintenance director said at the time there was no remote emergency shut off for the emergency generator. Upon observing the generator on 12/01/11 at 2:50 p.m. with the maintenance director and administrator, there was no emergency stop provided for the emergency generator.</p> <p>3.1-19(b)</p>		<p>Emergency generator on the property therefore there is not other inspection required need per the alleged deficiency. Installation of remote stop station completed on 12/14/2011.</p> <p>3. The Maintenance Director/Designee will monitor proper functioning through the testing of remote stop station at the time of required monthly emergency generator full load testing and will document results on Emergency Generator Inspection Test form (See attachment I)</p> <p>4. The Maintenance Director/Designee will review the Emergency Generator Inspection form with the Executive Director on a monthly/prn basis.</p> <p>Compliance 12/23/2011</p>		

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K0147 SS=E	<p>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 2 of 13 wet locations for residents 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 19 residents in the west center smoke compartment.</p> <p>Findings include:</p> <p>Based on observations with the maintenance director and</p>	K0147	<p>K-147 NFPA 101 Life Safety Code Standard Electrical wiring and equipment is in accordance with NFPA 70, National Electric Code. 9.1.2 1. The Maintenance Director/Designee immediately inspected and installed GFCI (ground-fault circuit interrupter) In all identified locations per the alleged deficiency. Completed 12/06/2011 2. The Maintenance Director/Designee will check all other required areas for proper placement of required GFCI (ground-fault circuit interrupter) Installation of required GFCI will be completed by the Maintenance Director/Designee. Compliance 12/23/2011 3. The Maintenance Director/Designee will check all areas requiring a GFCI to ensure that the facility is meeting the alleged deficient practice. This will be done through the facility's monthly preventative Maintenance program (See attachment J). 4. The Maintenance Director/Designee will review Preventative Maintenance form with the Executive Director on a monthly/prn basis. Compliance 12/23/2011</p>	12/23/2011

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	<p>administrator on 12/01/11 between 1:00 p.m. and 1:10 p.m., the electrical outlet in the 200 C wing soiled utility room was located eight inches from the sink and an outlet in the beauty shop was twelve inches from the shampoo sink. The outlets were not provided with GFCI (ground fault circuit interrupter) to prevent electric shock. The maintenance director said at the time of observations, no GFCI protection was provided at the outlets. He said he was unsure of the location of circuit breakers serving the outlets, and he was sure no GFCI breakers were provided.</p> <p>3.1-19(b)</p>				