STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155761	A. BUILDING -- B. WING	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG MEADOWS	2 E TILDEN BROWNSBURG, IN 46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/12/25 Facility Number: 011367 Provider Number: 155761 AIM Number: 200851590 At this Emergency Preparedness survey, Brownsburg Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 147 certified beds. At the time of the survey, the census was 123. Quality Review completed on 05/16/25	E 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Brownsburg Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/12/25 Facility Number: 011367 Provider Number: 155761 AIM Number: 200851590 At this Life Safety Code survey, Brownsburg Meadows was found not in compliance with	K 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Brownsburg Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Carter		05/30/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 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 installed in all resident sleeping rooms. The facility has a capacity of 147 and a census of 123. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/16/25			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 2 of 7 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 20 residents, 2 staff and 2 visitors.	K 0293	**K293 Exit Signage** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **All doors to the outside of the facility will be identified as Exit or NO Exit to prevent doors from being mistaken. No Exit Signs posted at Main Entrance Lobby and Activities Room.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective	06/06/2025

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	155761	A. BUILDING 01 B. WING	05/12/2025

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	Findings include: Based on observations made with the Director of Plant Operations (D.P.O.), the Assistant Director of Plant Operations (ADPO) and the Facility Maintenance Support man (FMS) during a tour of the facility at 11:45 a.m., the door to the courtyard from the main entrance lobby was not identified as an exit, or not an exit. This item was discussed on 05/12 25 at 11:47 a.m. when the D.P.O. stated that someone had recently found the sign on the floor and turned it in to him to be re-hung on the door. Furthermore, on 05/12/25 at 12:17 p.m., the door to the courtyard from the activities room was also not posted with an EXIT sign or a NO EXIT sign. This item was discussed at the D.P.O. on 05/12/25 at 12:19 p.m. who stated that he would order another sign and have it hung on the door as soon as possible. This item was discussed again at the exit conference held on 05/12/25 with the Director of Plant Operations, the Assistant Director of Plant Operations, the Facility Maintenance Support man and the facility Executive Director. 3.1-19(b)		action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All Staff educated on doors that Exit and No Exit to outside of Facility. No Exit Sign posted at all times at doors to the outside of facility. Message sent to all staff via (Internal Messaging/ In Person) . Housekeeping Supervisor or designee to complete Facility Exit QAPI Tool Weeklyx4, Monthly x6 and quarterly thereafter.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Housekeeping Supervisor or designee to complete Facility Exit QAPI Tool Weeklyx4, Monthly x6 and quarterly thereafter.** by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to	

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			submit an amended plan of correction with the updated plan of correction date. **6/6/2025**	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances	K 0921	**K921 Electrical Equipment Testing** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **PCREE Portable patient care related electrical equip testing completed and complete documentation maintained.** how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice.** what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	06/06/2025

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	receive continuous training. This deficient practice affects all residents. Findings include: Based on observations made with the Director of Plant Operations (D.P.O.), the Assistant Director of Plant Operations (ADPO) and the Facility Maintenance Support man (FMS) during record review at 10:51 a.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observations made during a tour of the building revealed that the facility provided electric beds for all residents. The FMS stated that PCREE such as nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility and the machine to monitor and test these requirements was on back-order and the testing would be completed as soon as the machine arrived. This item was discussed again at the exit conference held on 05/12/25 with the Director of Plant Operations, the Assistant Director of Plant Operations, the Facility Maintenance Support man and the facility Executive Director. 3.1-19(b)		**Maintenance Director and Assistant Maintenance Director educated on conducting PCREE training and maintaining PCREE documentation . Maintenance Director or designee to complete PCREE QAPI Tool Weeklyx4, Monthly x6 and quarterly thereafter.** how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee to complete PCREE QAPI Tool Weeklyx4, Monthly x6 and quarterly thereafter.** by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **6/6/25**	