PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155503	A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/25/2024	
NAME OF PROVIDER OR SUPPLIER HUTSONWOOD AT BRAZIL			STREET ADDRESS, CITY, STATE, ZIP COD 501 S MURPHY AVE BRAZIL, IN 47834					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
E 0000 Bldg	conducted by the Ir accordance with 42 Survey Dates: 11/2 Facility Number: 0 Provider Number: 100 At this Emergency Hutsonwood at Bra compliance with En Requirements for N Participating Provides 483.73 The facility has a caund had a census of	25/24 000514 155503	E 000	00	ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Buroker, On Nov 25,2024 life safety sur (DDPX21) was conducted by to Indiana State Department of Health. Enclosed please find to Statement of Deficiencies with facilities Plan of Correction for alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desireview that the facility has achieved substantial complian with the applicable requirement as of the date set forth in the Fof Correction of 12/10/2024. Please feel free to call me with any further questions at 1 (812) 446-2636.	rvey the he our the		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Manoj Berry Executive Director 12/09/2024

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DDPX21 Facility ID: 000514 If continuation sheet Page 1 of 6

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155503	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 11/25/2024					
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		Respectfully submitted, Manoj Berry (Executive Direct Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	or)			
Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Findings include: Based on records review of 'Test Generator Under Load' with the Maintenance Director and Executive Director on 11/25/24 at 12:31 p.m., the generator set in service was exercised less than 30 minutes for one of the last twelve months. The generator was ran under load for 20 minutes for the month of July 2024. Based on interview at the time of record review, the Maintenance Director agreed that the monthly load testing documentation provided for July 2024 showed the generator did not run for the required 30 minutes. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.	E 0041	Plan of Correction is the center credible allegation of compliance. Preparation and/of execution of this plan of correct does not constitute admission agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because is required by the provisions of federal and state law. 1) Immediations taken for those resider identified: No residents were for to be affected by this alleged deficiency. 2) How the facility identified with other residents: Visitors, staff and residents that reside in the community have the potential be affected by the alleged defipractice. No one was affected. Maintenance Director and	r ction or he se it f diate nts bund			
	ROVIDER OR SUPPLIER MOOD AT BRAZIL SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Findings include: Based on records review of 'Test Generator Under Load' with the Maintenance Director and Executive Director on 11/25/24 at 12:31 p.m., the generator set in service was exercised less than 30 minutes for one of the last twelve months. The generator was ran under load for 20 minutes for the month of July 2024. Based on interview at the time of record review, the Maintenance Director agreed that the monthly load testing documentation provided for July 2024 showed the generator did not run for the required 30 minutes. This finding was reviewed with the Executive Director and Maintenance Director at the exit	ABUILDING B. WING STREET 501 S BRAZIL SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Findings include: Based on records review of 'Test Generator Under Load' with the Maintenance Director and Executive Director on 11/25/24 at 12:31 p.m., the generator set in service was exercised less than 30 minutes for one of the last twelve months. The generator was ran under load for 20 minutes for the month of July 2024. Based on interview at the time of record review, the Maintenance Director agreed that the monthly load testing documentation provided for July 2024 showed the generator did not run for the required 30 minutes. This finding was reviewed with the Executive Director and Maintenance Director at the exit	ROVIDER OR SUPPLIER NOOD AT BRAZIL SUMMARY STATEMENT OF DEFICIENCIE (EACII DEFICIENCY MUST BE PRECEIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NPPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Findings include: Based on records review of "Test Generator Under Load" with the Maintenance Director and Executive Director on 11/25/24 at 12:31 p.m., the generator set in service was exercised less than 30 minutes for one of the last twelve months. The generator was ran under load for 20 minutes for the month of July 2024. Based on interview at the time of record review, the Maintenance Director agreed that the monthly load testing documentation provided for July 2024 showed the generator did not run for the required 30 minutes. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. BIOD PREFEIX TAGO SMURPHY AVE BRAZIL, IN 47834 BREAZIL, IN 47834 BREAZIL, IN 47834 BRESPECTION CORRECTION CORRECTION CORRECTION SHOULD BE SHAVE AVE BRAZIL, IN 47834 BRESPECTIVE ATTOR SHAVE AVE BRAZIL, IN 47834 BRESPECTIVE ATTOR SHAVE AVE BRAZIL, IN 47834 BRESPECTIVE AVE BRAZIL, IN 47834 BRESTAL IN 47834 BROWNERS PLANG CORRECTION CORRECTION SHOULD BE ASSOCIATED AVE BRAZIL, IN 47834 BRESPECTIVE AVE BRAZIL. BRAZIL, IN 47834 BRESPECTIVE AVE BRAZIL TAG BRESPECTIVE AVE BRAZIL BRAZIL, IN 47834 BRESPECTIVE AVE BRAZIL TAG BRAZIL AVE BRAZIL TAG BRESPECTIVE AVE BRAZIL TAG BRAZIL AVE BRAZIL TAG BRAZIL AVE BRAZI			

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Event ID:

DDPX21 Facility ID: 000514

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

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Resulting Number: 000514 Provider Number: 155503 A Life Safety Number: 100266800 Recember 100266800 Recommendations to revise the plan of correction as indicated.5) Date of compliance:12/10/2024. Recommendations to revise the plan of correction as indicated.5) Date of compliance:12/10/2024.						QA Committee will identify any	/	
R 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 Dates: 11/25/24 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 A Life Safety Code Recertification and State Licensure Survey and State Licensure Survey are conducted by the Indiana Department of Health in accordance with 42 CFR A83.90(a). A Life Safety Code Recertification and State Licensure Survey are conducted by the Indiana Department of Health in accordance with 42 CFR Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave						trends or patterns and make		
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 Dates: 11/25/24 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave								
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Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 11/25/24 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave	Bldg. 01							
Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 11/25/24 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave		1		K 000	00	ISDH		
483.90(a). Care 2 North Meridian Street Indianapolis, Indiana 46204 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave		I -	<u>-</u>					
Survey Dates: 11/25/24 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 Pacility Number: 100266800 Provider Number: 100266800 Provider Number: 100266800 Provider Number: 100266800 Provider Number: 100266800		_	Ith in accordance with 42 CFR				1	
Survey Dates: 11/25/24 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave		483.90(a).						
Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave		C D / 11/0	05/24					
Provider Number: 155503 AIM Number: 100266800 Hutsonwood at Brazil 501 S Murphy Ave		Survey Dates: 11/2	25/24			indianapolis, Indiana 46204		
Provider Number: 155503 AIM Number: 100266800 Hutsonwood at Brazil 501 S Murphy Ave		Facility Number: 0	000514			Re: Life safety Annual Survey		
AIM Number: 100266800 501 S Murphy Ave						-		
		AIM Number: 100	266800			501 S Murphy Ave		

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Event ID:

DDPX21

Facility ID: 000514

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>01</u>		COMPLETED		
155503		B. WING		11/25/2024			
NAME OF PROVIDER OR SUPPLIER HUTSONWOOD AT BRAZIL			STREET ADDRESS, CITY, STATE, ZIP COD 501 S MURPHY AVE BRAZIL, IN 47834				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROTURNING IN A 1 YOUR CORPORATION	(X5)		
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION At this Life Safety Code survey, Hutsonwood at Brazil was found in substantial compliance with 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 105 and had a census of 65 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached garage used as a maintenance shop and one small wood shed used for facility storage. Quality Review completed on 11/27/24			Dear Ms. Buroker, On Nov 25,2024 life safety si (DDPX21) was conducted by Indiana State Department of Health. Enclosed please find Statement of Deficiencies wir facilities Plan of Correction for alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a dereview that the facility has achieved substantial compliance with the applicable requirement as of the date set forth in the of Correction of 12/10/2024. Please feel free to call me with any further questions at 1 (8) 446-2636. Respectfully submitted, Manoj Berry (Executive Direct	the the th our or the ad f sk ance ents Plan th		
				501 S Murphy Ave Brazil, IN 47834-0130			
K 0918	NFPA 101			Biazii, iiv +7004-0100			
SS=C Bldg. 01	Electrical Systems	s - Essential Electric Syste					
	failed to maintain a	view and interview, the facility complete written record of oad testing for 1 of the last 12	K 0918	K 918 Electrical systems The facility requests paper compliance for this citation.	12/10/2024 This		

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED	
155503			B. WING		11/25/2024	
NAME OF PROVIDER OR SUPPLIER HUTSONWOOD AT BRAZIL			501 S N	ADDRESS, CITY, STATE, ZIP COD MURPHY AVE _, IN 47834		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	months. Chapter 6	.4.4.1.1.4(a) of 2012 NFPA 99		Plan of Correction is the center	er's	
	requires monthly te	esting of the generator serving		credible allegation of		
	the emergency elec	trical system to be in		compliance. Preparation and/	or	
	accordance with NI	FPA 110, the Standard for		execution of this plan of corre	ction	
	Emergency and Sta	indby Powers Systems, Chapter		does not constitute admission	or	
	8. NFPA 110 8.4.2.	.4 requires spark-ignited		agreement by the provider of	the	
	_	be exercised at least once a		truth of the facts alleged or		
	month with the ava	ilable EPSS load for 30 minutes		conclusions set forth in the		
		emperature and the oil pressure		statement of deficiencies. The	;	
		napter 6.4.4.2 of NFPA 99		plan of correction is prepared		
	_	ecord of inspection,		and/or executed solely because	se it	
	performance, exercising period, and repairs for the			is required by the provisions of	of	
	generator to be regularly maintained and available			federal and state law.1)Immed	diate	
	for inspection by the authority having			actions taken for those reside	nts	
	jurisdiction. This deficient practice could affect all			identified:No residents were for	ound	
	occupants.			to be affected by this alleged		
				deficiency.2) How the facility		
	Findings include:			identified with other		
				residents:Visitors, staff and		
		eview of 'Test Generator Under		residents that reside in the		
		ntenance Director and		community have the potential		
		on 11/25/24 at 12:31 p.m., the		be affected by the alleged def		
	_	vice was exercised less than 30		practice. No one was affected	. The	
		the last twelve months. The		Maintenance Director and		
	-	under load for 20 minutes for		Maintenance personnel were		
	-	2024. Based on interview at the		educated by the Executive		
	time of record review, the Maintenance Director			Director on essential electric		
	agreed that the mor			system maintenance and testi	-	
	documentation provided for July 2024 showed the generator did not run for the required 30 minutes. This finding was reviewed with the Executive			to ensure the generator is ran		
				under load for the required 30		
				minutes. 3) Measures put into		
				place/ System changes:The		
	Director and Maintenance Director at the exit			ED/Designee will review the		
	conference.			monthly generator load test w	nicn	
				is completed for 30 minutes		
	3.1-19(b)			monthly x 6 months to ensure		
				compliance. 4)How the correct	tive	
				actions will be monitored:The		
	I		1	Executive Director will review	the I	

Preventative Maintenance

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2024 FORM APPROVED OMB NO. 0938-039

CENTERSTON	WIEDICHNE & MEDIC	IID SERVICES				0.1.2	B 110. 0200 002
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEA		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPLETED		
		155503	B. WI	NG		11/25/	2024
NAME OF PROVIDER OR SUPPLIER HUTSONWOOD AT BRAZIL			STREET ADDRESS, CITY, STATE, ZIP COD 501 S MURPHY AVE BRAZIL, IN 47834				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					Worksheets monthly. The rest of these audits will be reviewed the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated Date of compliance:12/10/202	ed in g . The y e l.5)	

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