STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155480	A. BUILDING -- B. WING	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROOKVILLE HEALTHCARE CENTER	11049 STATE ROAD 101 BROOKVILLE, IN 47012

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/09/24 Facility Number: 000550 Provider Number: 155480 AIM Number: 100286110 At this Emergency Preparedness survey, Brookville Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 43. Quality Review completed on 01/10/24	E 0000		
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: 01/09/24 Facility Number: 000550 Provider Number: 155480 AIM Number: 100286110 At this Life Safety Code survey, Brookville Health	K 0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on this survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. Please accept this Plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Beverly Tackitt	Administrator	01/16/2024

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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	Care Center was found not in 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 (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 43 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinklered. The facility had two detached wooden storage barns which was not sprinklered. Quality Review completed on 01/10/24		Correction as our credible allegation of compliance.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that			

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	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 01/09/24 between 1:05 p.m. and 2:45 p.m., Room #212 the Medical Records Office area, greater than 50 square feet contained a number of combustible items, such as, paper and 100 or more cardboard boxes. The corridor door to this office did not self-close and latch into the door frame. This finding was acknowledged by the Executive Director and Maintenance Director at the time of	K 0321	1&2. No residents or staff were affected but all residents and staff had the potential to be affected. The Corridor door to the medical records office located in room # 212 was repaired with a self-closing device and ensured that the door self-closed and latched into the door frame. 3. The Maintenance Director was re-educated on Hazardous Areas-Corridor doors. A new visual inspection sheet has been initiated. 4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete. Any negative findings will be corrected immediately and reported to the	01/17/2024

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	observation and again at the exit conference with both present. 3.1-19(b)		administrator, a visual inspection of the medical records corridor door will be documented on inspection form, any negative findings will be corrected immediately and reported to the administrator. Monitoring will be conducted 5 times per week X 3 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in the QA meetings for continued compliance. Monitoring will be ongoing. 5. The above corrective actions will be completed on or before January 17, 2024.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible			

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	if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 1. Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 01/09/24 between 1:05 p.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Activities Lounge Corridor Door failed to latch. b) The "IT" room near the nurses station - equipped with a self-closing device, failed to	K 0363	1&2. No residents or staff were affected but all residents and staff had the potential to be affected. Corridor Doors to Activity Room, IT room and Activity lounge were repaired. Activity room door and IT room door were both adjusted to ensure they positivity latched in place. The Activity room lounge door was repaired with fire caulking to hole near door knob. 3. The Maintenance Director was re-educated on Corridor Doors latching requirements as well as corridor requirements to resist passage of smoke. A new visual inspection sheet has been initiated.	01/17/2024

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	self-close and latch into the door frame. This finding was acknowledged by the Executive Director and Maintenance Director at the time of observation and again at the exit conference with both present. 2. Based on observation and interview, the facility failed to ensure 1 of over 50 corridor doors would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based on observations during a tour of the facility with the Executive Director and Maintenance Director on 01/09/24 between 1:05 p.m. and 2:45 p.m., the corridor door to the Activities Lounge had a hole above the knob measuring approximately 3/8ths of an inch. The Maintenance Director agrees the door would not resist the passage of smoke. This finding was acknowledged by the Executive Director and Maintenance Director at the time of observation and again at the exit conference with both present. 3.1-19(b)		4. As a means of quality assurance, the Maintenance Director or designee will be responsible to complete visual inspection form and report any negative findings will be corrected immediately and reported to the administrator. Monitoring will be conducted 5 times per week X 3 weeks, weekly X 4 weeks, monthly X 2 months then quarterly thereafter. Results of the findings will be reviewed at least quarterly in QA meetings for continued compliance. Monitoring will be ongoing. 5. The above corrective actions will be completed on or before January 17, 2024.	