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	03/20/2024

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: 03/20/24 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 137. Quality Review completed on 03/21/24	E 0000	/p> ="" p="">	
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: 03/20/24 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	/p> ="" p="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Timothy Carter 04/03/2024

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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	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 137. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/21/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 32 residents, 6 staff and 4 visitors. Findings include: Based on observations with the Director of Maintenance (DOM) and the Maintenance Support Director (MSD) during a tour of the facility on 03/20/24 at 11:55 a.m., the exit identified as Exit #5 was marked as a facility exit, was magnetically locked and could be opened by entering a four-digit code, but the code was not posted at the exit. Based on interview at the time of the observation, the DOM stated the aforementioned facility exit was indeed identified as an exit and could be opened by entering a four-digit code, but the code was not posted adding that a resident may have peeled off the door code sticker as he had just changed the door codes throughout the facility recently and was certain that he placed a sticker with the code on it at that location.	K 0222	**K222 – Egress Doors** **· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **Means of Egress readily accessible, code posted at door Exit #5** **· 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**	04/05/2024

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	This item was discussed at the exit conference on 03/20/24 with the Director of Maintenance and the Maintenance Support Director. 3.1-19(b)		**to ensure that the deficient practice does not recur;** Maintenance Director or designee to complete Door Code Inspection log. Log to be completed weekly x4 monthly x6 and quarterly thereafter to ensure code posted at all doors. · **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 Door Code Inspection log. Log to be completed weekly x4 monthly x6 and quarterly thereafter to ensure code posted at all doors.** · **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**	

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			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. **4/05/2023**	
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 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			

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	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.			
	Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing or latching, and would resist the passage of smoke. This deficient practice could affect 18 residents, 6 staff and 4 visitors. Findings include: Based on observations with the Director of Maintenance (DOM) and the Maintenance Support Director (MSD) during a tour of the facility on 03/20/24 at 12:53 p.m., the corridor doors serving as the entrance to the Activities room was propped in the fully open position with an affixed kick down door stop on each of the double-doors. Based on interview at the time of observation, the DOM acknowledged the aforementioned corridor door was propped in the fully open position with a wedge placed on the floor.	K 0363	**K363 – Corridor Doors** **· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **No impediment to closing or latching corridor doors. Wedge, affixed kickdown door stop removed from corridor door.** **· how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will**	04/05/2024

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	This item was discussed at the exit conference on 03/20/24 with the Director of Maintenance and the Maintenance Support Director. 3.1-19(b)		**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;** **Maintenance Director or designee to complete Door Inspection log. Log to be completed weekly x4 monthly x6 and quarterly thereafter to ensure code posted at all doors.** **· 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 Door Inspection log. Log to be**	

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			completed weekly x4 monthly x6 and quarterly thereafter to ensure code posted at all doors. **· 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.** **4/05/2023**	