STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155487	A. BUILDING -- B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWN COUNTY HEALTH AND LIVING COMMUNITY	55 E WILLOW ST NASHVILLE, IN 47448

(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: 08/29/22 Facility Number: 000479 Provider Number: 155487 AIM Number: 100290880 At this Emergency Preparedness survey, Brown County Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 117 certified beds. At the time of the survey, the census was 106. Quality Review completed on 08/31/22	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: 08/29/22 Facility Number: 000479 Provider Number: 155487 AIM Number: 100290880 At this Life Safety Code survey, Brown County	K 0000	Sept 15, 2022 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance	

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

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	Health and Living Community was found not in compliance with Requirements for Participation in Medicare, 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) and 410 IAC 16.2. Building 01, Building 02 and Building 03 were surveyed with Chapter 19, Existing Health Care Occupancies. This one-story facility consists of two sections: the original buildings, Building 01 and 02, were determined to be of Type V (111) construction and fully sprinklered. Building 03, the new Therapy Room and adjoining support rooms built in 2011, is of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has hard wired smoke detectors in resident sleeping rooms E8 through E14 and has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 117 and had a census of 106 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage buildings which were not sprinklered. Quality Review completed on 08/31/22		Event ID: QDP321 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on Aug 29, 2022. This letter is to inform you that the plan of correction attached is to serve as Brown County Health & Living Community credible allegation of compliance. We allege substantial compliance on September 12, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-988-6666 Sincerely, Tyler Motsinger Administrator Brown County Health and Living Submission of this plan of correction in no way constitutes an admission by Brown County Health and Living or its	

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			management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure all public bathroom doors were provided with door latches that required only one operation to open. LSC 19.2.2.1 states doors complying with LSC 7.2.1 shall be permitted. LSC 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could staff in the kitchen. Findings include:	K 0200	**K200** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to ensure that the common area restroom doors only had 1 locking mechanism. The	09/12/2022

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	Based on observations made on 08/29/22 during a tour of the facility with the Director of Maintenance from 11:55 a.m. to 1:32 p.m., the following was noted: all six public restrooms doors throughout the facility had both a locking door handle and an independent deadbolt lock mechanism attached to them. Based on interview at the time of observation, The Director of Maintenance confirmed that each of the six facility public restrooms doors did indeed have both a locking door handle and an independent deadbolt locking mechanism attached. During the exit conference with the facility Administrator and the Director of Maintenance at 2:44 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		Maintenance Supervisor has audited all restroom doors and replaced the lever style handles that had a locking mechanism. The occupied/ unoccupied dead bolt remains to lock the door. See attached picture showing 1 of the restroom doors without the locking device. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff on the east side of the building could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There will be no follow up audit tool since this is a permanent fix to the issue. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor all restroom doors their annual inspections to ensure no one replaces the level handle with a locking one in the future.	

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			V. Plan of Correction completion date. Plan of Completion date is September 12, 2022 /p>	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 5 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment	K 0211	**K211** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that the E Hall path of egress was free and clear. The Maintenance Supervisor has removed the items from the E Hall. See attached picture labeled E Hall. **II. The facility will identify other residents that may potentially be affected by the**	09/12/2022

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	This deficient practice could affect approximately 26 residents, 4 staff and 2 visitors. Findings include: Based on observations made on 08/29/22 during a tour of the facility with the Director of Maintenance at 1:02 p.m., there was a bed frame, three banker boxes of unknown personal belongings, a laundry basket full of personal belongings, and a Lazy-Boy recliner all being stored in the corridor adjacent to resident room #E 113. Based on interview with the Director of Maintenance at the time of the observation, he acknowledged the items in the corridor as being stored there and explained that they belonged to a deceased resident, and they were waiting on family members to come and pick the items up to remove them. During the exit conference with the facility Administrator and the Director of Maintenance at 2:44 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**deficient practice.** Resident and Staff on the E Hall could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There was an existing TELS Task to inspect all corridor doors monthly. CarDon Corporate has changed this to a weekly task for the next 6 months. (See attached Task labeled "Corridor Inspection") **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor and inspect all corridor doors during their annual inspections. **V. Plan of Correction completion date.** Plan of Completion date is September 12, 202 /p>	

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K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations made on 08/29/22 during a tour of the facility with the Director of Maintenance at 12:34 p.m., the fire alarm control panel had the incorrect time displayed. It read Thursday 8:57 p.m. on Monday 08/29/22 at 12:34 p.m. Based on interview at the time of observation, the Director of Maintenance indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed day and time updated on the fire alarm control panel. During the exit conference with the facility Administrator and the Director of Maintenance at 2:44 p.m., no additional information or evidence could be provided contrary to this deficient finding.	K 0345	**K345** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that the fire panel had the correct time and date on it. The Maintenance Supervisor contracted with Integrated Electronics to make a site visit and reprogram. This took place on September 2nd. See attached picture labeled fire Panel. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Resident and Staff could be affected by this deficiency.	09/08/2022

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	3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated to check the fire panel during all events to ensure it still has an accurate time and date on it. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will inspect the fire panel and annunciator panel during their annual inspections. **V. Plan of Correction completion date.** Plan of Completion date is September 8, 2022 /p>	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established			

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	routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review on 08/29/22 with the Director of Maintenance at 10:10 a.m., no documentation could be provided regarding a fire drill for the fourth quarter (October, November, or December) of 2021. Based on interview at the time of record review, the Director of Maintenance acknowledged that there was no additional available fire drill documentation available for review at the time of this survey adding that it must have been missed while he was on vacation. During the exit conference with the facility Administrator and the Director of Maintenance at 2:44 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)	K 0712	**K712** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to produce documentation for fire drills at the end of 2021. The Maintenance Supervisor was new and this time and did not properly documents the drills after they were completed. CarDon Corporate Facilities has re educated the Maintenance Supervisor on the frequency and documentation. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and Staff could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	09/12/2022

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			There was an existing Monthly TELS Task to conduct and documents a fire drill monthly. (See attached Task labeled “Fire Drill Task”) **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will monitor the fire drills and documentation during their annual inspections. **V. Plan of Correction completion date.** Plan of Completion date is September 12, 2022 /p> /p>	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated			

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	from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported	K 0923	**K923** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community failed to ensure that oxygen tanks stored in the O2 room were secured properly. The small tank	09/12/2022

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	in a proper cylinder stand or cart. This deficient practice could affect as many as 24 residents, 4 staff and 2 visitors. Findings include: Based on observations made on 08/29/22 during a tour of the facility with the Director of Maintenance at 1:19 p.m., one small green 'E' type oxygen cylinders was laying on the top metal storage shelf in the oxygen storage and transfilling room. Based on interview at the time of observation, the Director of Maintenance acknowledged the small 'E' type oxygen cylinders in the aforementioned oxygen storage and transfilling room was not properly chained or supported in a proper cylinder stand or cart. During the exit conference with the facility Administrator and the Director of Maintenance at 2:44 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		was removed from the shelf and stored properly. See attached picture labeled Oxygen Room. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Residents and Staff could be affected by this deficiency. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There was an existing TELS Task to inspect the oxygen room monthly. CarDon Corporate has changed this to a weekly task for the next 6 months. (See attached Task labeled “Oxygen Room Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the O2 room during their annual inspections to ensure the cylinders and properly secured. **V. Plan of Correction completion date.**	

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