| STATEMEN | T OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER   | (X2) MULTIPLE CO | ONSTRUCTION   | (X3) DATE SURVEY COMPLETED |
|----------|---|--|------------------|---|----------------------------|
|          |   | 155487   | B. WING          |   | 08/29/2022                 |
|          | ROVIDER OR SUPPLIER   | AND LIVING COMMUNITY   | 55 E W           | ADDRESS, CITY, STATE, ZIP COD<br>ILLOW ST<br>/ILLE, IN 47448  |                            |
| (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 APPROPRIA   | COMPLETION                 |
| TAG      | REGULATORY OR   | LSC IDENTIFYING INFORMATION  | TAG              | DEFICIENCY)   | 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 |  | E 0000           |   |                            |
|          | Facility Number: 0<br>Provider Number:<br>AIM Number: 1002  | 155487<br>290880   |                  |   |                            |
|          | County Health & Li<br>compliance with En<br>Requirements for M  | Preparedness survey, Brown Eving Community was found in mergency Preparedness Redicare and Medicaid lers and Suppliers, 42 CFR |                  |   |                            |
|          | the survey, the cens  |  |                  |   |                            |
|          | Quality Review con  | npleted on 08/31/22  |                  |   |                            |
| K 0000   |   |  |                  |   |                            |
| Bldg. 01 | Licensure Survey w  | 00479<br>155487  | 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 Complian | nce                        |
|          | At this Life Safety (   | Code survey, Brown County  |                  | J   |                            |

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

TITLE

(X6) DATE

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.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY                  |          |          |  |                  |            |
|--|-----------------------|--|----------|----------|--|------------------|------------|
| AND PLAN   | OF CORRECTION         | IDENTIFICATION NUMBER  |          | LDING    | 01   | COMPL            |            |
|  |                       | 155487   | B. WIN   | IG       |  | 08/29/           | 2022       |
| NAME OF B  |                       |  | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP COD  |                  |            |
| NAME OF P  | PROVIDER OR SUPPLIEF  | S.   |          |          | ILLOW ST   |                  |            |
| BROWN  | COUNTY HEALTH         | AND LIVING COMMUNITY   |          | NASHV    | ILLE, IN 47448   |                  |            |
| (X4) ID  | SUMMARY               | STATEMENT OF DEFICIENCIE                                     |          | ID       | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |
| PREFIX   | `                     | CY MUST BE PRECEDED BY FULL                                  | P        | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE               | COMPLETION |
| TAG  |                       | LSC IDENTIFYING INFORMATION                                  |          | TAG      | DEFICIENCY)  |                  | DATE       |
|  | _                     | Community was found not in                                   |          |          | Event ID: QDP321   |                  |            |
|  | -                     | equirements for Participation in                             |          |          |  |                  |            |
|  |                       | Subpart 483.90(a), Life Safety                               |          |          | Dear Mrs. Buroker:   |                  |            |
|  |                       | 012 edition of the National Fire ion (NFPA) 101, Life Safety |          |          | Please find enclosed the Plan  | of               |            |
|  |                       | 0 IAC 16.2. Building 01,                                     |          |          | Correction for the State Licens  |                  |            |
|  |                       | ilding 03 were surveyed with                                 |          |          | Survey conducted on Aug 29,  | oul <del>C</del> |            |
|  | _                     | g Health Care Occupancies.                                   |          |          | 2022. This letter is to inform y                                       | 'OLI             |            |
|  | - Improv 19, Existing | 5 care coupanoies.   |          |          | that the plan of correction  | Ju               |            |
|  | This one-story facil  | ity consists of two sections:                                |          |          | attached is to serve as Brown  |                  |            |
|  |                       | gs, Building 01 and 02, were                                 |          |          | County Health & Living   |                  |            |
|  | -                     | Type V (111) construction and                                |          |          | Community credible allegation  | of               |            |
|  | fully sprinklered. B  | uilding 03, the new Therapy                                  |          |          | compliance. We allege  |                  |            |
|  |                       | g support rooms built in 2011,                               |          |          | substantial compliance on  |                  |            |
|  | is of Type V (111)    | construction and fully                                       |          |          | September 12, 2022. We are   |                  |            |
|  | sprinklered. The fa   | cility has a fire alarm system                               |          |          | requesting paper compliance  | or               |            |
|  |                       | on in the corridor and in all                                |          |          | this plan of correction.   |                  |            |
|  | -                     | orridor. The facility has hard                               |          |          |  |                  |            |
|  |                       | ors in resident sleeping rooms                               |          |          | If you have any further question                                       |                  |            |
|  | -                     | l has battery operated smoke                                 |          |          | please do not hesitate to conta  | act              |            |
|  |                       | n all other resident sleeping                                |          |          | me at 812-988-6666   |                  |            |
|  | -                     | has a capacity of 117 and had a                              |          |          |  |                  |            |
|  | census of 106 at the  | e time of this survey.                                       |          |          | Sincerely,   |                  |            |
|  | All areas where res   | idents have customary access                                 |          |          |  |                  |            |
|  |                       | Il areas providing facility                                  |          |          | Tyler Motsinger  |                  |            |
|  | •                     | klered except two detached                                   |          |          | Administrator  |                  |            |
|  |                       | hich were not sprinklered.                                   |          |          | Brown County Health and Livi   | na               |            |
|  | <i>5 9</i> - ··       | 1  |          |          | 2 2 2, 1. 2 2  | 3                |            |
|  | Quality Review cor    | npleted on 08/31/22  |          |          |  |                  |            |
|  |                       |  |          |          |  |                  |            |
|  |                       |  |          |          |  |                  |            |
|  |                       |  |          |          |  |                  |            |
|  |                       |  |          |          |  |                  |            |
|  |                       |  |          |          |  |                  |            |
|  |                       |  |          |          | Outeminain of their to   |                  |            |
|  |                       |  |          |          | Submission of this plan of   | _                |            |
|  |                       |  |          |          | correction in no way constitute  |                  |            |
|  |                       |  |          |          | an admission by Brown Count  | у                |            |
|  |                       |  |          |          | Health and Living or its   |                  |            |

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Event ID:

QDP321 Facility ID: 000479

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/21/2022 FORM APPROVED

| CENTERS FOR MEDICARE & MEDICAID SERVICES  OMB NO. |  |  |  |  |                                |                            |
|---|--|--|--|--|--------------------------------|----------------------------|
|   | IT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155487  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION 01   | (X3) DATE :<br>COMPL<br>08/29/ | ETED                       |
|   | PROVIDER OR SUPPLIE  | AND LIVING COMMUNITY   | 55 E W                                     | ADDRESS, CITY, STATE, ZIP COD<br>/ILLOW ST<br>/ILLE, IN 47448  |                                |                            |
| (X4) ID<br>PREFIX<br>TAG                          | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)   | ΓE                             | (X5)<br>COMPLETION<br>DATE |
| K 0200<br>SS=E<br>Bldg. 01                        | NFPA 101 Means of Egress Means of Egress List in the REMAF Section 18.2 and requirements that provided K-tags, I information, along Safety Code or N should be include 18.2, 19.2 Based on observation | Requirements - Other Requirements - Other RKS section any LSC 19.2 Means of Egress are not addressed by the out are deficient. This I with the applicable Life FPA standard citation, d on Form CMS-2567.  | K 0200                                     | management company that the allegations contained in the su report is a true and accurate portrayal of the provision of nu care or other services provided this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.  This statement of deficiencies plan of correction will be review at the Monthly Quality Assurance/Assessment Committee meeting. | rvey<br>rsing<br>d in          | 09/12/2022                 |
|   | provided with door operation to open. I complying with LS 7.2.1.5.10.2 require open the door leaf v  | public bathroom doors were latches that required only one LSC 19.2.2.1 states doors C 7.2.1 shall be permitted. LSC as the releasing mechanism shall with not more than one. This deficient practice could |  | I. The corrective actions to b accomplished for those residents found to have been affected by the deficient practice.  Observation 1- The community   | 1                              |                            |

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Findings include:

Event ID:

QDP321

Facility ID: 000479

failed to ensure that the common

area restroom doors only had 1 locking mechanism. The

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                        | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |       |          | JRVEY   |               |            |
|--|------------------------|---|-------|----------|---|---------------|------------|
| AND PLAN   | OF CORRECTION          | IDENTIFICATION NUMBER                       | A. BU | JILDING  | 01  | COMPLET       | ΓED        |
|  |                        | 155487                                      | B. W  | ING      |   | 08/29/2       | 022        |
|  |                        |   |       | STREET A | ADDRESS, CITY, STATE, ZIP COD   |               |            |
| NAME OF P  | PROVIDER OR SUPPLIER   | t .   |       |          | ILLOW ST  |               |            |
| BROWN  | COUNTY HEALTH          | AND LIVING COMMUNITY                        |       |          | ILLE, IN 47448  |               |            |
|  |                        |   | 1     |          | ,   | <u> </u>      |            |
| (X4) ID  |                        | STATEMENT OF DEFICIENCIE                    |       | ID       | PROVIDER'S PLAN OF CORRECTION   |               | (X5)       |
| PREFIX   | `                      | CY MUST BE PRECEDED BY FULL                 |       | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE (          | COMPLETION |
| TAG  |                        | R LSC IDENTIFYING INFORMATION               | _     | TAG      |   |               | DATE       |
|  |                        | ons made on 08/29/22 during a               |       |          | Maintenance Supervisor has  |               |            |
|  | tour of the facility v |   |       |          | audited all restroom doors and  |               |            |
|  |                        | 11:55 a.m. to 1:32 p.m., the                |       |          | replaced the lever style handle   |               |            |
|  | -                      | d: all six public restrooms                 |       |          | that had a locking mechanism  |               |            |
|  | -                      | e facility had both a locking               |       |          | The occupied/ unoccupied dea  |               |            |
|  |                        | independent deadbolt lock                   |       |          | bolt remains to lock the door.  |               |            |
|  |                        | d to them. Based on interview               |       |          | attached picture showing 1 of   |               |            |
|  |                        | vation, The Director of                     |       |          | restroom doors without the loc  | KING          |            |
|  |                        | med that each of the six facility           |       |          | device.   |               |            |
|  | -                      | ors did indeed have both a                  |       |          | II The feetiles will be set   |               |            |
|  |                        | e and an independent deadbolt               |       |          | II. The facility will identify  |               |            |
|  | -                      | attached. During the exit                   |       |          | other residents that may  |               |            |
|  |                        | facility Administrator and the              |       |          | potentially be affected by the  | •             |            |
|  |                        | nance at 2:44 p.m., no additional           |       |          | deficient practice.   |               |            |
|  |                        | ence could be provided                      |       |          | Desident and Otaff and the case   | .             |            |
|  | contrary to this defi  | cient finding.                              |       |          | Resident and Staff on the eas   | St            |            |
|  | 2 1 10/h)              |   |       |          | side of the building could be   |               |            |
|  | 3.1-19(b)              |   |       |          | affected by this deficiency.  |               |            |
|  |                        |   |       |          |   |               |            |
|  |                        |   |       |          | III. The facility will put into   |               |            |
|  |                        |   |       |          | place the following systemat  |               |            |
|  |                        |   |       |          | changes to ensure that the  | .ic           |            |
|  |                        |   |       |          | deficient practice does not   |               |            |
|  |                        |   |       |          | -   |               |            |
|  |                        |   |       |          | recur.  |               |            |
|  |                        |   |       |          | There will be no follow up aud  | <sub>it</sub> |            |
|  |                        |   |       |          | tool since this is a permanent  |               |            |
|  |                        |   |       |          | to the issue.   | 11/4          |            |
|  |                        |   |       |          | 10 110 13340.   |               |            |
|  |                        |   |       |          | IV The facility will monitor  |               |            |
|  |                        |   |       |          | the corrective action by  |               |            |
|  |                        |   |       |          | implementing the following  |               |            |
|  |                        |   |       |          | measures.   |               |            |
|  |                        |   |       |          |   |               |            |
|  |                        |   |       |          | CarDon Corporate Facilities to  | eam           |            |
|  |                        |   |       |          | will monitor all restroom doors   |               |            |
|  |                        |   |       |          | their annual inspections to en  |               |            |
|  |                        |   |       |          | no one replaces the level hand  |               |            |
|  |                        |   |       |          | with a locking one in the future  |               |            |
|  |                        |   |       |          | I a looking one in the lutting  |               |            |

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Event ID:

QDP321 Facility ID: 000479

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CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155487 |   | r í   | JILDING | onstruction 01      | (X3) DATE (<br>COMPL<br>08/29/  | ETED                            |                            |
|---|---|---|---------|---------------------|---|---------------------------------|----------------------------|
|   | ROVIDER OR SUPPLIER   | AND LIVING COMMUNITY  |         | 55 E W              | ADDRESS, CITY, STATE, ZIP COD<br>ILLOW ST<br>ILLE, IN 47448   |                                 |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  | TE                              | (X5)<br>COMPLETION<br>DATE |
| K 0211<br>SS=E<br>Bldg. 01  | in accordance with of egress is continall obstructions to emergency, unless through 18/19.2.1 18.2.1, 19.2.1, 7.1 Based on observation facility failed to ma from obstructions in facility. LSC 19.2.3 required width shall equipment, provided conditions are met:  (a) The wheeled equipment (a) The wheeled equipment, program ad wheeled equipment (b) The health care training program ad wheeled equipment emergency.  (c) The wheeled equipment in use in Equipment in use | Ageneral ays, corridors, exit cations, and accesses are a Chapter 7, and the means uously maintained free of full use in case of a modified by 18/19.2.2  1 | K 0     | 211                 | V. Plan of Correction completion date.  Plan of Completion date is September 12, 2022 /p>  K211  I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation 1- The Communit failed to ensure that the E Hall path of egress was free and cl The Maintenance Supervisor hall. See attached picture labeled E Hall.  II. The facility will identify other residents that may potentially be affected by the | ty<br> <br> <br>  ear.<br>  nas | 09/12/2022                 |

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Event ID:

 $QDP321 \qquad {\tt Facility \, ID:} \quad 000479$ 

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

PRINTED: 09/21/2022 FORM APPROVED OMB NO. 0938-039

|                          | T OF DEFICIENCIES  DF CORRECTION   | IDENTIFICATION NUMBER  155487  | A. BUILDING  B. WING | 01  | COMPLETED 08/29/2022      |
|--------------------------|--|--|----------------------|---|---------------------------|
|                          | ROVIDER OR SUPPLIER  | AND LIVING COMMUNITY   | 55 E W               | ADDRESS, CITY, STATE, ZIP COD<br>ILLOW ST<br>VILLE, IN 47448  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | (X5) COMPLETION DATE      |
|                          | REGULATORY OR This deficient practi 26 residents, 4 staff Findings include:  Based on observation tour of the facility we Maintenance at 1:02 three banker boxes of belongings, a laundre belongings, and a Lastored in the corridor 113. Based on intervent Maintenance at the stacknowledged the its stored there and expedience and expedience at the stored there and expedience at the start of the stored there and expedience at the stored there are the stored the st | ec could affect approximately and 2 visitors.  Ins made on 08/29/22 during a with the Director of e.p.m., there was a bed frame, of unknown personal exybasket full of personal exy-Boy recliner all being er adjacent to resident room #E with the Director of time of the observation, he eems in the corridor as being elained that they belonged to a end they were waiting on come and pick the items up to g the exit conference with the or and the Director of ep.m., no additional ence could be provided |                      | deficient practice.  Resident and Staff on the E H could be affected by this deficiency.  III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.  There was an existing TELS T to inspect all corridor doors monthly. CarDon Corporate h changed this to a weekly task 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 to will monitor and inspect all corrections.  V. Plan of Correction completion date.  Plan of Completion date is September 12, 202 | ic DATE  ic ask as for or |
|                          |  |  | I                    | 1   |                           |

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Event ID:

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155487 |  | A. BU   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                     |  | (X3) DATE SURVEY COMPLETED 08/29/2022 |                            |
|--|--|---|--|---------------------|--|---------------------------------------|----------------------------|
|  | ROVIDER OR SUPPLIER  | AND LIVING COMMUNITY  |  | 55 E W              | ADDRESS, CITY, STATE, ZIP COD<br>ILLOW ST<br>VILLE, IN 47448   |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | .TE                                   | (X5)<br>COMPLETION<br>DATE |
| K 0345<br>SS=C<br>Bldg. 01   | in accordance with complying with the National Electric Contional Fire Alarr Records of system and testing are readed as the system and the syste | in is tested and maintained in an approved program requirements of NFPA 70, code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available.  FPA 70, NFPA 72 in and interview, the facility refire alarm system to assure time and date information in requirements of NFPA 101-ins 19.3.4 and 9.6 and NFPA 72 it all residents, staff, and interview, the facility refire alarm system to assure time and date information in requirements of NFPA 101-ins 19.3.4 and 9.6 and NFPA 72 it all residents, staff, and residents, staff, and residents, staff, and residents and residents are alarm control rect time displayed. It read on Monday 08/29/22 at 12:34 riew at the time of rector of Maintenance rector of Maintenance rector of the discrepancy and rector of the discrepancy and rector of the control rector of the p.m., no additional rece could be provided | K 0  | 345                 | K345  I. The corrective actions to I accomplished for those residents found to have been affected by the deficient practice.  Observation 1- The Communifialed to ensure that the fire partial had the correct time and date it. The Maintenance Supervistic contracted with Integrated Electronics to make a site visitiand reprogram. This took platon September 2nd. See attack 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. | ty anel on cor t ce hed               | 09/08/2022                 |

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

PRINTED: 09/21/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155487 |  | (X2) MULTIPLE C A. BUILDING B. WING   | onstruction<br><u>01</u> | (X3) DATE SURVEY COMPLETED 08/29/2022   |                      |
|--|--|---|--------------------------|---|----------------------|
|  | PROVIDER OR SUPPLIE  | R<br>I AND LIVING COMMUNITY   | 55 E W                   | ADDRESS, CITY, STATE, ZIP COD<br>/ILLOW ST<br>/ILLE, IN 47448   |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                 | (X5) COMPLETION DATE |
| mo   | 3.1-19(b)  | RESCRIPTION OR SERVICE  | o                        | III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur.     |                      |
|  |  |   |                          | The Maintenance Supervisor been re educated to check the panel during all events to ens still has an accurate time and on it. | e fire<br>ure it     |
|  |  |   |                          | IV The facility will monitor the corrective action by implementing the following measures.                                    |                      |
|  |  |   |                          | CarDon Corporate Facilities to will inspect the fire panel and annunciator panel during their annual inspections.             |                      |
|  |  |   |                          | V. Plan of Correction completion date.  |                      |
|  |  |   |                          | Plan of Completion date is<br>September 8, 2022<br>/p>  |                      |
| K 0712<br>SS=F<br>Bldg. 01   | alarm signal and conditions. Fire d and unexpected t conditions, at least the staff is familiary | the transmission of a fire simulation of emergency fire rills are held at expected imes under varying st quarterly on each shift. ar with procedures and is |                          |   |                      |

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| STATEMEN  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA         | (X2) MULTIPLE CONSTRUCTION |           | ONSTRUCTION  | (X3) DATE SURVEY |            |
|-----------|----------------------|------------------------------------|----------------------------|-----------|--|------------------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER              | A. BU                      | JILDING   | 01   | COMPLI           | ETED       |
|           |                      | 155487                             | B. W                       | NG        |  | 08/29/           | 2022       |
|           |                      |                                    |                            | STREET    | ADDRESS, CITY, STATE, ZIP COD  |                  |            |
| NAME OF I | PROVIDER OR SUPPLIEI | R                                  |                            |           | ILLOW ST   |                  |            |
| BROWN     | COUNTY HEALTH        | I AND LIVING COMMUNITY             |                            |           | /ILLE, IN 47448  |                  |            |
| DITOTIT   | ·                    | TAND EIVING COMMONT                |                            | 147 (0117 | , III 47 440   |                  |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | ATE              | COMPLETION |
| TAG       |                      | R LSC IDENTIFYING INFORMATION      |                            | TAG       | DEFICIENCY)  |                  | DATE       |
|           |                      | rills are conducted between        |                            |           |  |                  |            |
|           | 9:00 PM and 6:00     |                                    |                            |           |  |                  |            |
|           |                      | ay be used instead of              |                            |           |  |                  |            |
|           | audible alarms.      |                                    |                            |           |  |                  |            |
|           | 19.7.1.4 through     |                                    |                            |           |  |                  |            |
|           |                      | view and interview, the facility   | K 0                        | 712       | K712   |                  | 09/12/2022 |
|           |                      | uarterly fire drills for 1 of 4    |                            |           | l  |                  |            |
|           | _                    | .1.6 requires drills to be         |                            |           | I. The corrective actions to I   | be               |            |
|           |                      | y on each shift under varied       |                            |           | accomplished for those   |                  |            |
|           |                      | ficient practice affects all staff |                            |           | residents found to have been   | n                |            |
|           | and residents.       |                                    |                            |           | affected by the deficient  |                  |            |
|           | Findings insteads    |                                    |                            |           | practice.  |                  |            |
|           | Findings include:    |                                    |                            |           | Observation 1 The Communication  | <b>.</b>         |            |
|           | Događ an ragard ra   | view on 08/29/22 with the          |                            |           | Observation 1- The Communi   | -                |            |
|           |                      | nance at 10:10 a.m., no            |                            |           | failed to produce documentati  |                  |            |
|           |                      | ld be provided regarding a fire    |                            |           | -  | 1                |            |
|           |                      | quarter (October, November, or     |                            |           | The Maintenance Supervisor new and this time and did not               |                  |            |
|           |                      | . Based on interview at the time   |                            |           | properly documents the drills  |                  |            |
|           |                      | ne Director of Maintenance         |                            |           | they were completed. CarDor  |                  |            |
|           |                      | there was no additional            |                            |           | Corporate Facilities has re  | '                |            |
|           | _                    | documentation available for        |                            |           | educated the Maintenance   |                  |            |
|           |                      | of this survey adding that it      |                            |           | Supervisor on the frequency a  | and              |            |
|           |                      | ssed while he was on vacation.     |                            |           | documentation.   |                  |            |
|           |                      | aference with the facility         |                            |           | documentation.   |                  |            |
|           |                      | the Director of Maintenance at     |                            |           | II. The facility will identify   |                  |            |
|           | 2:44 p.m., no addit  | ional information or evidence      |                            |           | other residents that may   |                  |            |
|           | _                    | contrary to this deficient         |                            |           | potentially be affected by the   | e                |            |
|           | finding.             | ,                                  |                            |           | deficient practice.  |                  |            |
|           |                      |                                    |                            |           |  |                  |            |
|           | 3.1-19(b)            |                                    |                            |           | All Residents and Staff could  | be               |            |
|           | 3.1-51(c)            |                                    |                            |           | affected by this deficiency.   |                  |            |
|           |                      |                                    |                            |           |  |                  |            |
|           |                      |                                    |                            |           |  |                  |            |
|           |                      |                                    |                            |           | III. The facility will put into  |                  |            |
|           |                      |                                    |                            |           | place the following systemat   | tic              |            |
|           |                      |                                    |                            |           | changes to ensure that the   |                  |            |
|           |                      |                                    |                            |           | deficient practice does not  |                  |            |
|           |                      |                                    |                            |           | recur.   |                  |            |
|           |                      |                                    |                            |           |  |                  |            |

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

PRINTED: 09/21/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155487 |  | (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVE         A. BUILDING       01       COMPLETED         B. WING       08/29/2022 |  |                     | ETED  |     |                            |
|--|--|--|--|---------------------|---|-----|----------------------------|
|  | ROVIDER OR SUPPLIER  | AND LIVING COMMUNITY   |  | 55 E WI             | ADDRESS, CITY, STATE, ZIP COD<br>ILLOW ST<br>ILLE, IN 47448   |     |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)          | ATE | (X5)<br>COMPLETION<br>DATE |
|  |  |  |  |                     | There was an existing Monthl TELS Task to conduct and documents a fire drill monthly (See attached Task labeled "f Drill Task") |     |                            |
|  |  |  |  |                     | IV The facility will monitor<br>the corrective action by<br>implementing the following<br>measures.                             |     |                            |
|  |  |  |  |                     | CarDon Corporate Facilities to will monitor the fire drills and documentation during their ar inspections.                      |     |                            |
|  |  |  |  |                     | V. Plan of Correction completion date.  |     |                            |
|  |  |  |  |                     | Plan of Completion date is<br>September 12, 2022<br>/p><br>/p>  |     |                            |
| K 0923<br>SS=E<br>Bldg. 01   | Storag Gas Equipment - 0 Storage Greater than or ecceptions and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or withir space of non- or li construction, with that can be secure |  |  |                     |   |     |                            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QDP321

Facility ID: 000479

If continuation sheet

Page 10 of 13

| NAME OF PROVIDER OR SUPPLIER  BROWN COUNTY HEALTH AND LIVING COMMUNITY  O(4) ID PRIERY (BACH DEPTEINS 'M STATEMENT OF DEFICIENCIE PRIERY (BACH ADDRESS, CITY, STATE, ZIP COD SERVICION ST NASHVILLE, IN 47448   TAG  STREET ADDRESS, CITY, STATE, ZIP COD SERVICION ST NASHVILLE, IN 47448   TAG  STREET ADDRESS, CITY, STATE, ZIP COD SERVICION ST NASHVILLE, IN 47448  (XS)  COMPLETION  COMPLETION  TAG  (XS)  COMPLETION  TAG  TAG  STREET ADDRESS, CITY, STATE, ZIP COD SERVICION ST NASHVILLE, IN 47448  (XS)  COMPLETION  TAG  (XS)  COMPLETION  TAG  TAG  STREET ADDRESS, CITY, STATE, ZIP COD SERVICION ST NASHVILLE, IN 47448  (XS)  COMPLETION  TAG  TAG  (XS)  COMPLETION  TAG  TAG  TAG  TAG  STREET ADDRESS, CITY, STATE, ZIP COD SERVICION  TAG  TO SERVICION ST NASHVILLE, IN 47448  (XS)  COMPLETION  TAG  TAG  TAG  TAG  TAG  TAG  TAG  TA   | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                        | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV |       |          | SURVEY                              |                |                |
|--|--|------------------------|---|-------|----------|-------------------------------------|----------------|----------------|
| STREET ADDRESS, CITY, STATE_ZIP COD 55 E WILLOW ST NASHVILLE, IN 47448  SOMMARY STATEMENT OF DEFICIENCE PRETIX TAG REGILATORY OF SEC DENTIFYING INFORMATION from combustibles by 20 feet (5 feet if sprinkfered) 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 (NPPA 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 fulling. NPPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases such as oxygen were properly secured from fulling. NPPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 85 cubic meters (300 cubic feet) but less than 85 cubic meters (300 cubic feet) but less than 85 cubic meters (300 cubic feet) but less than 85 cubic meters (300 cubic feet) but less than 85 cubic meters (300 cubic feet) but less than 85 cubic meters (300 cubic feet) but less than 85 cubic meters (300 cubic feet) but less than 85 cubic meters (300 cubic feet) but les | AND PLAN   | OF CORRECTION          |   | A. BU | JILDING  |                                     |                |                |
| BROWN COUNTY HEALTH AND LIVING COMMUNITY    SAMMARY STATEMENT OF DEFICIENCE   PREFIX   SAMMARY STATEMENT OF DEFICIENCE   PREFIX   RACH COMMUNITY   PREFIX   TAG  |  |                        | 155487                                    | B. W  | NG       |                                     | 08/29/         | /2022          |
| SE WILLOW ST   NASHVILLE, IN 47448   SEWING STORES   | NAME OF I  | DROVIDED OD STIDDI IEI |   | •     | STREET A | ADDRESS, CITY, STATE, ZIP COD       |                |                |
| OX5   DIAMARY STATEMENT OF DEFICIENCIE   ID   PROFIDE    |  |                        |   |       |          |                                     |                |                |
| PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  from combustible to 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: CXIDIZING 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 nonllammable 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 (300 cubic feet) ball 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 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.5 dates cylinder or container restraints shall comply with 11.3.2.1 through 11.3.2.3 through  | BROWN  | COUNTY HEALTH          | AND LIVING COMMUNITY                      |       | NASHV    | 'ILLE, IN 47448                     |                |                |
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| 11.6.2.3. Section 11.6.2.3(11) states freestanding stored in the O2 room were  |  | -                      |   |       |          |                                     | -              |                |
|  |  | · ·                    |   |       |          |                                     |                |                |
| cylinders shall be properly chained or supported secured properly. The small tank  |  | cylinders shall be p   | roperly chained or supported              |       |          | secured properly. The small to      | ank            |                |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QDP321 Facility ID: 000479

If continuation sheet Page 11 of 13

|                    | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155487   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   | (X3) DATE SURVEY COMPLETED 08/29/2022 |  |
|--------------------|--|--|--|---|---------------------------------------|--|
|                    | PROVIDER OR SUPPLIEF   | AND LIVING COMMUNITY   | 55 E W   | ADDRESS, CITY, STATE, ZIP COD<br>/ILLOW ST<br>/ILLE, IN 47448   |                                       |  |
| (X4) ID PREFIX TAG | summary (EACH DEFICIEN REGULATORY OF in a proper cylinder practice could affect staff and 2 visitors.  Findings include:  Based on observative tour of the facility of Maintenance at 1:11 oxygen cylinders we storage shelf in the transfilling room. Expression observation, the Diracknowledged the se in the aforemention transfilling room we supported in a prop During the exit con Administrator and to 2:44 p.m., no additi | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION To stand or cart. This deficient et as many as 24 residents, 4  The standard of the standa | ID PREFIX TAG                                    | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  was removed from the shelf at 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 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 To inspect the oxygen room monthly. CarDon Corporate he changed this to a weekly task the next 6 months. (See attached Task labeled "Oxyge Room Task"  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate Facilities we inspect the O2 room during the annual inspections to ensure to cylinders and properly secured.  V. Plan of Correction completion date. | ic DATE  ic ic iii iii iii eir he     |  |
|                    |  |  |  |   |                                       |  |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/21/2022 FORM APPROVED

| ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093                   |   |                             |                                      |   |  |                  |            |
|---|---|-----------------------------|--------------------------------------|---|--|------------------|------------|
| 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        |            |
| 155487  |   | B. WING                     |                                      |   | 08/29/2022   |                  |            |
| NAME OF PROVIDER OR SUPPLIER BROWN COUNTY HEALTH AND LIVING COMMUNITY |   |                             |                                      | STREET ADDRESS, CITY, STATE, ZIP COD 55 E WILLOW ST NASHVILLE, IN 47448 |  |                  |            |
| (X4) ID   | SUMMARY S                                 | STATEMENT OF DEFICIENCIE    |                                      | ID  | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |
| PREFIX  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL |                             | PREFIX (EACH CORRECTIVE ACTION SHOUL |   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA |                  | COMPLETION |
| TAG   | REGULATORY OR                             | LSC IDENTIFYING INFORMATION |                                      | TAG   | DEFICIENCY)  |                  | DATE       |
|   |   |                             |                                      |   | Plan of Completion date is<br>September 12, 2022<br>/p>                |                  |            |

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