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	09/16/2024

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: 09/16/24 Facility Number: 000479 Provider Number: 155487 AIM Number: 100290880 At this Emergency Preparedness survey, Brown County Health and 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 110. Quality Review completed on 09/23/24	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: 09/16/24 Facility Number: 000479 Provider Number: 155487 AIM Number: 100290880 At this Life Safety Code survey, Brown County	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tyler Motsinger	Administrator	10/16/2024

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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	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 Building 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 also 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 110 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 trailers which were not sprinklered and one detached garage for further storage and where the facility bus parks which was also not sprinklered. Quality Review completed on 09/23/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of	K 0222	**K 222**	10/06/2024

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	1 entrances to the memory care unit 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 31 residents, staff and visitors in this smoke compartment. Findings include: Based on observations on 09/16/2024 between 1:00 PM and 3:30 PM during a tour of the facility with the Maintenance Director and Regional Maintenance Supervisor, the door to the memory care unit did not have the code posted coming on the unit to actuate the door release. Based on interview at the time of observation, the Maintenance Director stated he had been told by others within the company that the code did not need to be posted coming on to the unit, but did at exit doors. This finding was reviewed with the Maintenance Director, Regional Maintenance Supervisor, and Administrator at the exit conference. 3.1-19(b)		**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 door access code to the internal memory care door was posted coming into the unit. The Maintenance Supervisor has posted the code on the keypad to enter the memory care unit. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates 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.** This is a permanent fix to this deficient practice so no follow up will be needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team	

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			will inspect this door to ensure the code is posted during their monthly site visits. **V. Plan of Correction completion date.** Plan of Completion date is October 6th, 2024	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the door to the social services office which was over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff, visitors, and residents in this smoke compartment. At the time of observation, at least 4 staff members were located in the area of the social services office. Findings include: Based on observations on 09/16/24 between 1:00 PM and 3:30 PM with the Maintenance Director and Regional Maintenance Supervisor, the door to the social services office was not equipped with a self-closing mechanism. The social services office contained at least 16 cardboard boxes, a stack of papers 20 inches tall, 6 additional stacks of papers, and additional combustible materials. Based on interview at the time of observation, the Maintenance Director stated the office was 120 square feet and agreed there was a significant amount of combustible material and there was no self-closing mechanism on the door. The social services staff measured the largest stack of papers	K 0321	**K 321** **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 door to the social services office had a self-closing device since there are a large number of combustible items in there. The Maintenance Supervisor has added spring hinges to the door. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates could be affected by this deficiency.	10/06/2024

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	to be 20 inches tall, when the Maintenance Director was asked the height of the stack of papers This finding was reviewed with the Maintenance Director, Regional Maintenance Director, and Administrator at the exit conference. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent fix to this deficient practice so no follow up will be needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will inspect the social services door and office during their site visits to ensure the spring hinges shut and latch properly. **V. Plan of Correction completion date.** Plan of Completion date is October 6th, 2024	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s)	K 0324	**K 324** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The Community	10/06/2024

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	acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect at least 20 residents in the dining room and kitchen staff. Findings include: Based on review of the contracted vendor's exhaust cleaning "Work Order" documentation dated 08/16/23 and 09/15/24 with the Maintenance Director and Regional Maintenance Supervisor on 09/16/24 between 10:30 AM and 1:00 PM, documentation of semiannual kitchen exhaust system inspection six months after 08/16/23 was not available for review. Based on interview at the time of record review, the Maintenance Director stated to his knowledge, the contracted vendor had not come to the facility 6 months after 08/16/23.		failed to ensure that the commercial kitchen hood was cleaned within the last 6 months. The Maintenance Supervisor has contracted with Hoodz and it was cleaned on Sept 15th. See attached documentation. Observation 2- The Community failed to ensure that the range in the therapy gym and in the memory care dining room had appropriate shut off switches. The Maintenance Supervisor has contacted an electrical contractor to move the switches within the cooking area. This will be completed by 10/17/2024. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates 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.** Observation 1: There is a current semi annual TELS task to have the kitchen hood cleaned by an outside contractor. This task has been updated with the months that it is due. See attached TELS task labeled “Brown County Kitchen	

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	This finding was reviewed with the Administrator, Maintenance Director, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in West Dining and 1 of 1 cooktops in Memory Care Dining. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could impact at least 35 residents in these areas. Findings include: During a tour of the facility with the Maintenance Director and Regional Maintenance Supervisor on 09/16/2024 between 1:00 PM and 3:30 PM, there		Hood Cleaning Task. Observation 2: There will be no follow up on this corrective measure because this is a permanent solution. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will inspect the kitchen hood paperwork during their annual CQR to ensure it is getting cleaned every 6 months. **V. Plan of Correction completion date.** Plan of Completion date is October 6th, 2024	

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	was a cooktop stove/oven in the West Dining room and the emergency shut off was located in the storage room across the hall. Additionally in the Memory Care Dining room there was a cooktop stove/oven present with the emergency shut off being located in an adjacent room which shares a wall with the Memory Care Dining. The finding was reviewed with Maintenance Director, Regional Maintenance Supervisor, and Administrator at the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 E hall med rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff. Findings include: Based on observation during a tour of the facility on 09/16/24 between 1:00 PM and 3:30 PM with the Maintenance Director and Regional Maintenance Supervisor, a 1 inch by 0.75 inch penetration was observed in the ceiling of the E hall med room near the AC unit. Based on interview at the time of observation, the	K 0353	**K 353** **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 med room had any holes or penetrations. The Maintenance Supervisor has patched the ceiling in the E Hall med room. See attached picture showing the hole in the E Hall med room has been patched. Observation 2- The Community failed to ensure that a sprinkler head in the memory care dining room was up tight to the ceiling. The Maintenance Supervisor has adjusted the hanger on the	10/06/2024

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	Maintenance Director agreed there was a penetration in the ceiling in the aforementioned location and provided the measurement. This finding was reviewed with the Maintenance Director, Regional Maintenance Supervisor, and Administrator at the exit conference. 3.1-19(b) 2. Based on observation, the facility failed to maintain 1 of 16 sprinklers in the memory care dining room in accordance with NFPA 25, Standard of Inspection, Testing and Maintenance of Water Based Fire Protection System. This deficient practice could affect all staff and clients. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Regional Maintenance Supervisor on 09/16/2024 between 1:00 PM and 3:30 PM, 1 of 16 sprinkler heads in the memory care dining room had dropped 1.5 inches, exposing the metal piping. Based on interview at the time of the observations, the Maintenance Director agreed the sprinkler heads in the above locations had dropped and as a result the metal piping was exposed. This finding was reviewed with the Maintenance Director, Regional Maintenance Supervisor, and Administrator at the time of the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchen freezers in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.		sprinkler pipe to pull the sprinkler head back up tight to the drywall. See attached picture showing the memory care sprinkler head is up tight to the ceiling. Observation 3- The Community failed to ensure that the kitchen walk in Freezer had the proper escutcheon in place. The Maintenance Supervisor has contracted with PIPE Inc to get the proper escutcheon installed. See attached picture showing the walk in freezer. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates 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 is a current quarterly TELS task to have the Maintenance Supervisor inspect the entire community to ensure the sprinkler heads are compliant. See attached TELS task labeled "Brown County Sprinkler Head	

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	NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff in this area. Findings include: Based on observation during a tour of the facility on 09/16/24 between 1:00 PM and 3:30 PM with the Maintenance Director and Regional Supervisor, an escutcheon was missing in the kitchen freezer. Based on interview at the time of observation, the Maintenance Director agreed there was a missing escutcheon in the aforementioned location. This finding was reviewed with the Maintenance Director, Regional Maintenance Supervisor, and the Administrator at the exit conference. 3.1-19(b)		Inspection". **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will inspect the sprinkler system during their annual CQR to ensure all the sprinkler heads are tight to the ceiling with proper escutcheons. **V. Plan of Correction completion date.** Plan of Completion date is October 6th, 2024	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 D4 rooms was able to latch into the frame. This deficient practice could affect 2 residents. Findings include: Based on observation during a tour of the facility on 09/16/24 between 1:00 PM and 3:30 PM with the Maintenance Director and Regional Maintenance Supervisor, the door to room D4 was unable to latch into the frame. Based on interview at the time of observation, the Maintenance	K 0363	**K 363** **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 resident room door D4 shut and latched properly. The Maintenance Supervisor has repaired the door frame to resident	10/06/2024

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	Director agreed the door to room D4 did not latch fully into the frame. This finding was reviewed with the Maintenance Director, Regional Maintenance Supervisor, and Administrator at the exit conference. 3.1-19(b)		room D4 to ensure it shuts and latched properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates 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 is a current semi annual TELS task to have the kitchen hood cleaned by an outside contractor. This task has been updated with the months that it is due. See attached TELS task labeled “Brown County Door Inspection Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will inspect all doors to the corridor during their annual door inspection. **V. Plan of Correction completion date.**	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations through 1 of 1 smoke barrier walls near room D2 was protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff, 20 residents, and visitors in this smoke compartment. Findings include: Based on observation during a tour of the facility on 09/16/24 between 1:00 PM and 3:30 PM with the Maintenance Director and Regional Maintenance Supervisor, a penetration of 0.5 inches by 0.25 inches was located on 1 side of the smoke barrier wall near room D2. Based on interview at the time of observation, the Maintenance Director agreed there was a penetration in the aforementioned location and provided the measurement. The penetration was corrected at the time of observation. This finding was reviewed with the Maintenance Director, Regional Maintenance Supervisor, and the Administrator at the exit conference. 3.1-19(b)	K 0372	Plan of Completion date is October 6th, 2024 **K 372** **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 wall near resident room D2 had no open penetrations. The Maintenance Supervisor has repaired the fire wall. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and associates 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 is a current Quarterly TELS	10/06/2024

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			task to inspect the fire walls for penetrations. See attached TELS task labeled “Brown County Fire Wall TELS Task”. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will inspect all fire wall during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 6th, 2024	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 09/16/2024 between 10:30 AM and 1:00 PM with the Maintenance Director and Regional Maintenance Supervisor, the first quarter, second quarter, and third quarter first shift fire drills were conducted at 8:14 AM, 10:15 AM, and 8:05 AM, respectively. Based on interview at the time of record review, the Maintenance Director agreed the aforementioned first shift fire drills were not conducted at	K 0712	**K 712** **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 their monthly fire drills were conducted at different times and frequency. The Maintenance Supervisor has been re educated on the proper time and frequency of fire drills. **II. The facility will identify**	10/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155487	A. BUILDING 01 B. WING	09/16/2024

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

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	unexpected times under varying conditions. This finding was reviewed with the Maintenance Director, Administrator, and Regional Maintenance Supervisor at the exit conference. 3.1-19(b) 3.1-51(c)		**other residents that may potentially be affected by the deficient practice.** All residents and associates 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.** The Maintenance Supervisor has been re educated on the proper time and frequency of fire drills. CarDon Corporate Facilities has made a master schedule for all fire drills for the next 12 months. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities team will audit the communities fire drill logs during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is October 6th, 2024	