STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155206	A. BUILDING -- B. WING	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG HEALTH CARE CENTER	1010 HORNADAY RD BROWNSBURG, IN 46112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/03/23 Facility Number: 000113 Provider Number: 155206 AIM Number: 100287670 At this Emergency Preparedness survey, Brownsburg Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 160 certified beds. At the time of the survey, the census was 64. Quality Review completed on 10/04/23	E 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Brownsburg Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they if such character as to limit the provider's capacity to render adequate resident care. Furthermore, Brownsburg Health Care Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance. The facility respectfully request a desk review.	
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	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Brushaber	Administrator	10/19/2023

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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	483.90(a). Survey Date: 10/03/23 Facility Number: 000113 Provider Number: 155206 AIM Number: 100287670 At this Life Safety Code survey, Brownsburg Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 160 and had a census of 64 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has three detached buildings that are used for a Maintenance shop / office and facility storage building, which were not sprinklered. Quality Review completed on 10/04/23		by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Brownsburg Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they if such character as to limit the provider's capacity to render adequate resident care. Furthermore, Brownsburg Health Care Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance. The facility respectfully request a desk review.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING			

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	Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects as many as 18 residents, 4 staff and 1 visitor. Findings include: Based on observations made on 10/03/23 at 1:44 p.m. with the Maintenance Director and the Regional Maintenance Director, the set of smoke barrier doors leading to the "Memory Care" unit had holes that went all the way through the door from a previous self-closing device installation. This meant that the door would no longer restrict the movement of smoke for at least 20 minutes. This was verified by the Regional Maintenance Director who stated that the door was scheduled to be replaced in the very near future. This item was discussed with the Maintenance	K 0374	**1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. A quote for the replacement of the doors leading to the Memory Care unit was signed and approved on 10/04/2023. b. The doors were measured and evaluated, and new doors were ordered on 10/11/23 as confirmed by letter from the third-party vendor to the maintenance director. c. It can reasonably be expected for the new doors to be installed no later than 11/10/23. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. The maintenance director, or designee will perform inspections of all other smoke barrier doors in the facility by 10/24/23 to ensure they are all installed to limit the	11/10/2023

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	Director, the Regional Maintenance Director, and the Director of Nursing during an exit conference on 10/03/23 at 2:35 p.m. 3.1-19(b)		movement of smoke. **3 What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?** a The maintenance director, or designee, will conduct monthly smoke barrier door inspections monthly X 2 months, and then semi-annually to ensure doors are installed to limit the movement of smoke. Inspections will be performed on an ongoing basis as part of the facility's life safety program. **4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a The administrator, or designee, will review the monthly smoke barrier door inspections for a period of 2 months, or longer if substantial compliance is not met. Any concerns will be reported monthly to the facility QA committee for further intervention or systematic changes until substantial compliance is met. **5 What date will the systemic change for the deficiency be completed?** a Compliance date of November 10, 2023	

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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 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 ensure 5 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff, and visitors in the facility. Findings include: Based on record review on 10/03/23 at 9:44 a.m. of the documentation entitled "Direct Supply - TELS - Conduct a fire drill on _ shift" with the Maintenance Director and the Regional Maintenance Director, the following was noticed: a) The fire drill conducted on 03/31/23 had "Did the monitoring company receive the alarm signal" answered N/A. "Person spoke with at the alarm company" was also answered N/A. b) The fire drill conducted on 06/25/23 had "Did the monitoring company receive the alarm signal" answered N/A. "Person spoke with at the alarm	K 0712	**1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** a. The maintenance director, or designee, will perform a fire drill on or before 10/31/23 and coordinate with the monitoring company to confirm signal transmission. Signal transmission will be documented on the fire drill form. **2 How will the facility identify other residents having the potential to be affected by the same deficient practice?** a. The facility only utilizes one monitoring company for remote monitoring of the fire alarm system so no further evaluation is needed. **3 What measures will be put into place or systemic changes made to ensure that the**	10/31/2023

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	company" was also answered N/A. c) The fire drill conducted on 08/19/23 had "Did the monitoring company receive the alarm signal" answered N/A. "Person spoke with at the alarm company" was also answered N/A. d) The fire drill conducted on 09/30/23 had "Did the monitoring company receive the alarm signal" answered N/A. "Person spoke with at the alarm company" was also answered N/A. e) The fire drill conducted on 12/31/23 had "Did the monitoring company receive the alarm signal" answered N/A. "Person spoke with at the alarm company" was also answered N/A. Based on interview at the time of record review, the Maintenance Director verified that the fire alarm signal had not been verified as being received at the alarm monitoring company adding that he would remember to documents this in all future fire drills. This item was discussed with the Maintenance Director, the Regional Maintenance Director, and the Director of Nursing during an exit conference on 10/03/23 at 2:35 p.m. 3.1-19(b) 3.1-51(c)		**deficient practice will not recur?** a The maintenance director, or designee, will continue to conduct monthly fire drills at random times, so that a fire drill occurs on each shift every quarter. For every drill there will be coordination with the monitoring company to confirm signal transmission. Drills will be performed on an ongoing basis as part of the facility's life safety program. **4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** a The administrator, or designee, will review the monthly fire drill documentation for a period of 3 months, or longer if substantial compliance is not met. Any concerns will be reported monthly to the facility QA committee for further intervention or systematic changes until substantial compliance is met. **5 What date will the systemic change for the deficiency be completed?** a Compliance date of October 31, 2023	