PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

CE.TEROTOR	THE WIND OF THE CONTROL OF THE CONTR	THE SERVICES			012 101 0700 007	
STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
155206		155206	B. WING		10/03/2023	
			CEDEDA	CADDRESS CITY STATE ZIR COR		
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD		
DDOMA		ADE CENTED		HORNADAY RD		
RKOMNS	SBURG HEALTH C	AKE CENTEK	BROW	VNSBURG, IN 46112		
(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 Prep	paredness Survey was	E 0000	Preparation and/or execution	of	
	conducted by the Indiana Department of Health in			this plan of correction does no		
	accordance with 42	-		constitute admission or agree		
				by the provider of the truth of		
	Survey Date: 10/03	3/23		facts alleged or the conclusion		
	54110y Date. 10/03/23			set forth in the Statement of		
	Facility Number: 0	000113		Deficiencies rendered by the		
	Provider Number:			reviewing agency. The Plan o	f	
	AIM Number: 100287670			Correction is prepared and	·	
	1111111110111001111100	26,6,6		executed solely because it is		
	At this Emergency	Preparedness survey,		required by the provisions of		
		Care Center was found in		federal and state law. Browns	hura	
	compliance with Emergency Preparedness			Health Care Center maintains	-	
	Requirements for Medicare and Medicaid			alleged deficiencies do not	ule	
	-	ders and Suppliers, 42 CFR		_	alth	
	483.73	iers and Suppliers, 42 Cr K		individually jeopardize the hea		
	403.73			and/or safety of its residents r		
	The facility has 160	certified beds. At the time of		are they if such character as t		
	-			limit the provider's capacity to		
	the survey, the cens	sus was 64.		render adequate resident care		
	Ovality P	mulated on 10/04/22		Furthermore, Brownsburg Hea		
	Quanty Keview cor	mpleted on 10/04/23		Care Center asserts that it is i	in	
				substantial compliance with		
				regulations governing the ope		
				of long-term care facilities, an	d	
				this Plan of Correction in its		
				entirety constitutes the provid		
				credible allegation of complian	nce.	
				The facility respectfully reques	st a	
				desk review.		
IX 0000						
K 0000						
Dida 04						
Bldg. 01		D CC C 100	TT 0000		,	
	-	Recertification and State	K 0000	Preparation and/or execution		
		vas conducted by the Indiana		this plan of correction does no		
	Department of Health in accordance with 42 CFR			constitute admission or agreemer		

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

TITLE

(X6) DATE

Emily Brushaber Administrator 10/19/2023

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.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCT		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>		COMPLETED		
155206		155206	B. WING			10/03/2023		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					ORNADAY RD			
BROWNSBURG HEALTH CARE CENTER					NSBURG, IN 46112			
(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	TE.	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	483.90(a).				by the provider of the truth of t			
					facts alleged or the conclusion	าร		
	Survey Date: 10/03	3/23			set forth in the Statement of			
	F 71: 37 1 0	00112			Deficiencies rendered by the	_		
	Facility Number: 0				reviewing agency. The Plan of	Ť		
	Provider Number:				Correction is prepared and			
	AIM Number: 100	28/6/0			executed solely because it is			
	At this Life Cafety	Codo august Duoremahana		required by the provisions of				
	-	Code survey, Brownsburg			federal and state law. Browns	•		
	Health Care Center was found not in compliance			Health Care Center maintains the alleged deficiencies do not				
	with Requirements for Participation in				individually jeopardize the hea	alth		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the				and/or safety of its residents n			
	National Fire Protection Association (NFPA) 101,				are they if such character as to			
	Life Safety Code (LSC), Chapter 19, Existing				limit the provider's capacity to			
	Health Care Occupancies and 410 IAC 16.2.				render adequate resident care			
					Furthermore, Brownsburg Hea			
	This one-story facility was determined to be of				Care Center asserts that it is i			
	Type III (200) construction and fully sprinklered.				substantial compliance with			
		re alarm system with smoke			regulations governing the ope	ration		
	detection in the corr	ridors and in all areas open to			of long-term care facilities, and			
	the corridor. The fa	cility has battery operated			this Plan of Correction in its			
	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				entirety constitutes the provide	er's		
					credible allegation of compliar	nce.		
					The facility respectfully reques	st a		
					desk review.			
	_	sed for a Maintenance shop /						
	office and facility storage building, which were							
	not sprinklered.							
	Quality Review con	npleted on 10/04/23						
K 0374	NFPA 101							
SS=E	Subdivision of Bui	lding Spaces - Smoke						
Bldg. 01	Barrie							
	Subdivision of Building Spaces - Smoke							
	Barrier Doors							
	2012 EXISTING							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 10/03/2023 155206 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1010 HORNADAY RD BROWNSBURG HEALTH CARE CENTER BROWNSBURG, IN 46112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0374 How will corrective action 11/10/2023 failed to ensure 1 of 7 sets of smoke barrier doors be accomplished for those would restrict the movement of smoke for at least residents found to have been 20 minutes. LSC, Section 19.3.7.8 requires that affected by the deficient doors in smoke barriers shall comply with LSC, practice? Section 8.5.4. LSC, Section 8.5.4.1 requires doors a. A quote for the replacement in smoke barriers to close the opening leaving of the doors leading to the only the minimum clearance necessary for proper Memory Care unit was signed and operation which is defined as 1/8 inch to restrict approved on 10/04/2023. the movement of smoke. This deficient practice b. The doors were measured affects as many as 18 residents, 4 staff and 1 and evaluated, and new doors visitor. were ordered on 10/11/23 as confirmed by letter from the Findings include: third-party vendor to the maintenance director. Based on observations made on 10/03/23 at 1:44 c. It can reasonably be p.m. with the Maintenance Director and the expected for the new doors to be Regional Maintenance Director, the set of smoke installed no later than 11/10/23. barrier doors leading to the "Memory Care" unit had holes that went all the way through the door How will the facility from a previous self-closing device installation. identify other residents having This meant that the door would no longer restrict the potential to be affected by the movement of smoke for at least 20 minutes. the same deficient practice? This was verified by the Regional Maintenance a. The maintenance director, or Director who stated that the door was scheduled designee will perform inspections to be replaced in the very near future. of all other smoke barrier doors in the facility by 10/24/23 to ensure This item was discussed with the Maintenance they are all installed to limit the

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Event ID:

YWPS21

Facility ID: 000113

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

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155206		A. BU	a. building <u>01</u>			X3) DATE SURVEY COMPLETED 10/03/2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD ORNADAY RD		
BROWNS	SBURG HEALTH C	ARE CENTER			NSBURG, IN 46112		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION SHOULD BE			(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
		nal Maintenance Director, and			movement of smoke.		
		sing during an exit conference					
	on 10/03/23 at 2:35 p.m. 3.1-19(b)				3 What measures will be	-	
					into place or systemic chan made to ensure that the	ges	
					deficient practice will not		
					recur?		
					a The maintenance direct	or, or	
					designee, will conduct month	-	
					smoke barrier door inspection		
					monthly X 2 months, and the		
					semi-annually to ensure door installed to limit the moveme		
					smoke. Inspections will be	iii Oi	
					performed on an ongoing bas	sis as	
					part of the facility's life safety		
					program.		
					4 How will the facility		
					monitor its corrective action	ns to	
					ensure that the deficient		
					practice will not recur?		
					a The administrator, or	-41-1.	
					designee, will review the mor smoke barrier door inspection	-	
					a period of 2 months, or long		
					substantial compliance is not		
					Any concerns will be reported		
					monthly to the facility QA		
					committee for further interver	ntion	
					or systematic changes until		
					substantial compliance is me	t.	
					5 What date will the		
					systemic change for the		
					deficiency be completed?		
					a Compliance date of		
					November 10, 2023		

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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				
155206		B. WING 10/03/				2023			
NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER			•	STREET ADDRESS, CITY, STATE, ZIP COD 1010 HORNADAY RD BROWNSBURG, IN 46112					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCE N. I.V. OF CORPORATION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE		
K 0712	NFPA 101								
SS=F	Fire Drills								
Bldg. 01	Fire Drills								
	Fire drills include t	the transmission of a fire							
	alarm signal and s	simulation of emergency fire							
	conditions. Fire dr	ills are held at expected							
	-	mes under varying							
	· ·	t quarterly on each shift.							
		r with procedures and is							
		re part of established							
		ills 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		IZ O	710	4 How will compositive coti		10/21/2022		
			K 0	/12	1 How will corrective acti be accomplished for those	on	10/31/2023		
	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				residents found to have been				
					affected by the deficient				
					practice? a. The maintenance director, or designee, will perform a fire drill on				
		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.				or before 10/31/23 and coordinate with the monitoring company to				
					confirm signal transmission.				
					Signal transmission will be				
	Findings include:				documented on the fire drill fo	rm.			
	Based on record review on 10/03/23 at 9:44 a.m. of				2 How will the facility				
	the documentation entitled "Direct Supply - TELS				identify other residents having the potential to be affected by				
- Conduct a fire drill on _ shift" with the									
	Maintenance Direct				the same deficient practice?	-			
	Maintenance Director, the following was noticed: a) The fire drill conducted on 03/31/23 had "Did				a. The facility only utilizes or				
					monitoring company for remote				
	the monitoring company receive the alarm signal"				monitoring of the fire alarm sy	stem			
		rson spoke with at the alarm			so no further evaluation is nee	eded.			
	company" was also								
		ducted on 06/25/23 had "Did			3 What measures will be p				
	_	pany receive the alarm signal"			into place or systemic chang	jes			
answered N/A. "Person spoke with at the alarm				made to ensure that the					

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Event ID:

YWPS21 Facility ID: 000113

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

PRINTED: 10/24/2023 FORM APPROVED OMB NO. 0938-039

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		
155206			B. WING 10/03/2023			/2023	
NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 1010 HORNADAY RD BROWNSBURG, IN 46112				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROUDERS N. AN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	company" was also	answered N/A.			deficient practice will not		
	c) The fire drill con-	ducted on 08/19/23 had "Did			recur?		
	the monitoring com	pany receive the alarm signal"			a The maintenance directo	r, or	
	answered N/A. "Per	rson spoke with at the alarm			designee, will continue to cond	duct	
	company" was also	answered N/A.			monthly fire drills at random tir		
	d) The fire drill con	ducted on 09/30/23 had "Did			so that a fire drill occurs on ea		
	the monitoring com	pany receive the alarm signal"			shift every quarter. For every	drill	
	answered N/A. "Per	rson spoke with at the alarm			there will be coordination with	the	
	company" was also answered N/A.			monitoring company to confirm			
	e) The fire drill conducted on 12/31/23 had "Did			signal transmission. Drills will be			
	the monitoring company receive the alarm signal"				performed on an ongoing basi	s as	
	answered N/A. "Person spoke with at the alarm				part of the facility's life safety		
	company" was also answered N/A.				program.		
	Based on interview at the time of record review,						
	the Maintenance Director verified that the fire				4 How will the facility		
	alarm signal had not been verified as being				monitor its corrective actions	s to	
	received at the alarm monitoring company adding				ensure that the deficient		
that he would remember to documents this in all				practice will not recur?			
future fire drills.				a The administrator, or			
					designee, will review the mont	-	
		ssed with the Maintenance			fire drill documentation for a p	eriod	
	Director, the Regional Maintenance Director, and			of 3 months, or longer if			
	the Director of Nursing during an exit conference		substantial compliance is not met.				
	on 10/03/23 at 2:35 p.m.		Any concerns will be reported				
					monthly to the facility QA		
	3.1-19(b)				committee for further intervent	tion	
	3.1-51(c)				or systematic changes until		
					substantial compliance is met.		
					5 What date will the		
					systemic change for the		
					deficiency be completed?		
					a Compliance date of Octo	ber	
					31. 2023		

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