STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155503	A. BUILDING -- B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

(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: 07/26/2022 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 At this Emergency Preparedness survey, Hutsonwood at Brazil was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 105 certified beds and had a census of 66 at the time of this visit. Quality Review completed on 07/28/22	E 0000	08/12/2022 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Buroker, On July 26,2022 life safety survey (ZTQI21) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Aug 12, 2022. Please feel free to call me with any further questions at 1 (812)	

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

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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			446-2636. Respectfully submitted, Manoj Berry (Executive Director) Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	
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: 07/26/2022 Facility Number: 000514 Provider Number: 155503 AIM Number: 100266800 At this Life Safety Code survey, Hutsonwood at Brazil 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 V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 105 and had	K 0000	08/12/2022 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Life safety Annual Survey Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130 Dear Ms. Buroker, On July 26,2022 life safety survey (ZTQI21) was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance.	

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	a census of 66 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached garage used as a maintenance shop and one small wood shed used for facility storage. Quality Review completed on 07/28/22		We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Aug 12, 2022. Please feel free to call me with any further questions at 1 (812) 446-2636. Respectfully submitted, Manoj Berry (Executive Director) Hutsonwood at Brazil 501 S Murphy Ave Brazil, IN 47834-0130	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace 1 of over 50 battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture.	K 0300	K300 PROTECTION The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of	08/12/2022

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	This deficient practice could affect 4 residents, staff, and visitors in the vicinity of resident room 218. Findings include: Based on observations with the Maintenance Director on 07/26/22 during a tour of the facility from 12:45 p.m. to 1:55 p.m., manufacturer's documentation affixed to the battery-operated smoke alarms installed in resident sleeping room 218 indicated the device was manufactured 02/06/2012. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke alarm was more than ten years old. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: No resident was found to be affected by this alleged deficiency. Smoke detector in resident room 218 was replaced. Itemized audit for all battery-operated smoke detectors completed and will be maintained and test accordance with manufacturer's instructions. 2) How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: Maintenance Director or Designee will conduct weekly audits to identify any potential problems. 4)How the corrective actions will	

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			be monitored: The Executive Director will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance:08/12/2022.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the	K 0353	K353 SPRINKLER SYSTEM-	08/12/2022

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	facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the facility's sprinkler gauge documentation for the most recent twelve-month period with the Maintenance Director during record review from 9:50 a.m. to 12:45 p.m. on 07/26/22, weekly dry sprinkler system gauge inspection documentation for 4 weeks of the most recent 52-week period was not available for review. The weeks not available for review were 08/21/2021, 12/11/2021, 12/18/2021 and 12/25/2021. Based on interview at the time of record review, the Maintenance Director stated he had been at the facility for two months and there was no further sprinkler system gauge inspection documentation for the aforementioned weekly periods available for review at the time of the survey.		MAINTENANCE AND TESTING The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: No resident was found to be affected by the finding. Maintenance Director and assistant maintenance are educated on preventive maintenance on sprinkler system inspection to check weekly to ensure that normal air and water pressures are being maintained. Spare sprinklers were ordered and are kept in storage cabinet where the temp will not exceed 100 Fahrenheit. Sprinkler located in the kitchen of the village wing was cleaned on 07/26/2022 by maintenance	

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	2. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the Maintenance Director on 07/26/22 during a tour of the facility from 12:45 p.m. to 1:45 p.m., the spare sprinkler cabinet in the riser room did not contain any sidewall sprinkler heads. Based on observation with the Maintenance Director, the facility had sidewall sprinklers in the lobby. Based on interview at the time of observation, the Maintenance Director agreed the spare sprinkler cabinet did not contain sidewall sprinkler heads. 3. Based on observation, and interview; the facility failed to ensure all loaded sprinklers were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection		director. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/ System changes: Maintenance director or designee will do weekly inspections on sprinkler systems to ensure that normal air and water pressures are being maintained and sprinklers heads are clean. Maintenance director will have supply of minimum 6 spare sprinklers at the facility at all times and will order on timely manner if spare is used. 4)How the corrective actions will be monitored: The Maintenance Director/designee will present the audits to the QAPI Committee during QAPI Meetings to ensure completion and compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 months The QA Committee will identify any trends or patterns and make	

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	Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect at least 5 residents and staff in the vicinity of the Villages kitchen. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:45 p.m. to 1:45 p.m. on 07/26/22, the sprinkler located in the kitchen of The Villages wing was covered with dirt and lint. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned automatic sprinkler was loaded with dust and lint. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		recommendations to revise the plan of correction as indicated. 5) Date of compliance: 08/12/2022.	

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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 1. Based on record review and interview, the facility failed to ensure 2 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 of the documentation entitled "Fire Drill Report" with the Maintenance Director on 07/26/22 from 9:50 a.m. to 12:45 p.m., the documentation for the following fire drills failed to include the verification of transmission of the fire alarm signal to the monitoring station: a) 05/31/22 at 5:20 a.m. b) 11/28/21 at 1:00 a.m. Based on interview at the time of record review, the Maintenance Director confirmed that the aforementioned fire drills did not document the	K 0712	K712 Fire drills The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: No resident was found to be	08/12/2022

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	verification of transmission of the fire alarm signal to the monitoring station. 2. Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill Report" forms with the Maintenance Director on 07/26/2022 from 9:50 a.m. to 12:45 p.m. there was no documentation for a first shift fire drill in the fourth quarter of 2021. Based on interview at the time of record review, the Maintenance Director stated he has been at the facility for two months and that there are no other fire drills available to review at the time of the survey. These findings were reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		affected by the finding. Maintenance Director and assistant maintenance are educated on preventive maintenance program on fire drills. Fire drills are held at expected or unexpected times under varying condition at least quarterly on each shift including verification of transmission of fire alarm signal to the monitoring station in the fire drills. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/ System changes: Maintenance director or designee will follow monthly TELS schedule on fire drills to ensure compliance. 4)How the corrective actions will be monitored: The Maintenance Director/designee will present the audits to the QAPI Committee during QAPI Meetings to ensure completion and compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved	

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			times 3 months The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 08/12/2022.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records			

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	of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections for the generator was maintained for 6 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 07/26/22 from 9:50 a.m. to 12:45 p.m., documentation for the weekly generator inspections for the weeks of 08/21/2021, 11/20/2021, 12/04/2021, 12/11/2021, 12/18/2021 and 12/25/2021 was not available for review. Based on an interview at the time of record review, the Maintenance Director confirmed no documentation for weekly generator inspections was available for review for the aforementioned time periods.	K 0918	K918 Electrical system The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. 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 conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: No resident was found to be affected by the finding. Maintenance Director and assistant maintenance are educated on preventive maintenance on Generator. Generator sets are inspected	08/12/2022

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	This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		weekly, exercised under load 30 minutes 12 times a year in 20-40 days intervals and exercised once every 36 months for 4 continuous hours and have a written records available. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice. 3)Measures put into place/ System changes: Maintenance director or designee created a weekly schedule of generator test to ensure compliance. 4)How the corrective actions will be monitored: The Maintenance Director/designee will present the audits to the QAPI Committee during QAPI Meetings to ensure completion and compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 months The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING 01 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HUTSONWOOD AT BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

(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
			5) Date of compliance: 08/12/2022.	