STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155761	A. BUILDING -- B. WING	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROWNSBURG MEADOWS	2 E TILDEN 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: 04/18/23 Facility Number: 011367 Provider Number: 155761 AIM Number: 200851590 At this Emergency Preparedness survey, Brownsburg Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 147 certified beds. At the time of the survey, the census was 129. Quality Review completed on 04/20/23	E 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Brownsburg Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	
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: 04/18/23 Facility Number: 011367 Provider Number: 155761 AIM Number: 200851590 At this Life Safety Code survey, Brownsburg Meadows was found not in compliance with	K 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's Inspection Report. Brownsburg Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Carter		05/15/2023

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	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 (111) 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 smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 147 and a census of 129. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 04/20/23			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation, and interview, the facility failed to ensure 29 of 29 battery backup lights were tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional	K 0291	**K291 – Emergency Lighting** · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Battery backup lights tested monthly and annually for 90 minutes. written record of visual inspections and tests**	04/26/2023

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	testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 04/19/23 at 10:32 a.m. with the Maintenance Director, the Battery-Operated Emergency Light Test Log for 2023 indicated twenty-nine battery operated lights located throughout the facility. The Direct Supply - TELS documentation provided for record review indicated 30 second testing for February of 2022 through March of 2023. No documentation of 90-minute testing could be provided during record review. Based on observations made during a tour of the facility with the Maintenance Supervisor on 04/19/23 from 12:00 p.m. to 2:30 p.m., the facility had a total of 29 battery operated exit lights located throughout the facility. The lack of annual testing of the twenty-nine battery operated exit lights was verified by the Maintenance Supervisor during the tour of the facility and again at the exit conference held on 04/19/23 at 2:30 p.m. 3.1-19(b)		**provided.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **90 minute test log updated to show all locations via TELS. Education provided to maintenance director on what information was requested and location of information.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **90 minute test log updated to show all locations via TELS. Education provided to maintenance director on what information was requested and location of information.** · by what date the systemic changes for each deficiency will	

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			be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **4/26/2023**	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of over 25 manual fire alarm boxes (pull stations) were not obstructed. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72 2010 edition 17.14.5 states manual fire alarm boxes shall be installed so that they are conspicuous, unobstructed, and accessible. This deficient practice could affect 28 residents, 4 staff and 2 visitors.	K 0345	**K345 Fire Alarm System** · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Manual fire alarm boxes (pull stations) not obstructed.** · how other residents having the potential to be affected by the same deficient practice will be	05/09/2023

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	Findings include: Based on observations made with the Maintenance Director on 04/18/23 at 1:40 p.m., the pull station on the 200 - F hall nurses' station had a cart parked in front of the pull station and was obstructed. Based on interview at the times of observation, the Maintenance Director agreed the cart was obstructing the pull station and asked staff to move it. 3.1-19(b)		identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **All staff educated on keeping manual pull station free from obstruction. Message sent to all staff via (Internal Messaging/ In Person) . Maintenance Director or designee to complete Fire Safety QAPI Tool Weeklyx4, Monthly x6 and quarterly thereafter.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Maintenance Director or designee to complete Fire Safety QAPI Tool Weeklyx4, Monthly x6 and quarterly thereafter.** · by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it	

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			is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **5/9/2023**	
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 facility failed to maintain 1 of 1 fire pump system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25,	K 0353	**K353 Sprinkler System #1** · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. *Annual Fire Pump Test Available*	05/17/2023

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	2011 Edition, 8.3.1.1 states electric engine-driven fire pumps shall be operated monthly. Table 8.1.1.2 states fire pumps systems shall be visually inspected weekly in accordance with 8.2.2. This deficient practice affects all occupants. Findings include: Based on record review on 04/19/23 at 10:51 a.m. with the Maintenance Director, the facility was unable to provide documentation of an annual operational test of the electric engine-driven fire pump. The most recent testing documentation for annual testing of the electric engine-driven fire pump was dated March of 2022. Based on an interview at the time of record review, the Maintenance Director stated that he thought the vendor had recently been in to test the fire-pump, but he could not locate the documentation of the testing as of the time of this survey. This item was again discussed at the exit conference with the Maintenance Supervisor held on 04/19/23 at 2:30 p.m. 3.1-19(b) 2) Based on record review, observation, and interview, the facility failed to ensure 3 of 16 sprinkler heads in the facility kitchen were clean, free of foreign materials, and corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 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		*for review. Maintenance Director Educated on how to obtain inspection and expectation to maintain records of service.* · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; *All residents have the potential to be affected by the alleged deficient practice.* · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; *Maintenance Director to review TELS Tasks weekly with ED and Monthly during QAPI.* · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and *Monthly During QAPI* · by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. *5/17/2023*	

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	sprinkler manufacturer. This deficient practice could affect as many as 5 staff in the kitchen. Findings include: Based on record review on 04/19/23 at 10:18 a.m. with the Maintenance Director, document entitled "Form for Inspection, Testing and Maintenance of Dry Pipe Fire Sprinkler Systems" stated "The sprinklers located in the kitchen area nearest to the kitchen hood system are loaded and need to be replaced". Based on observations made during a tour of the facility at 1:27 p.m., the same sprinkler heads were dirty and needed to be replaced. Based on an interview at the time of the observation, the Maintenance Director stated that he would contact his vendor and have the loaded sprinklers replaced as soon as he was able to do so. This item was again discussed at the exit conference with the Maintenance Supervisor held on 04/19/23 at 2:30 p.m. 3.1-19(b)		**#2** · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. *Supplies ordered from vendor to replace identified Sprinkler Heads in kitchen. Work scheduled to be completed 5/16/2023* · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; *All residents have the potential to be affected by the alleged deficient practice.* · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; *Sprinkler QAPI Tool to be completed weekly x4; monthly x6 and Quarterly thereafter.* · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and *Sprinkler QAPI Tool to be completed weekly x4; monthly x6 and Quarterly thereafter.* · by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division	

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			needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. *5/17/2023*	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.	K 0761	**K761 Door Testing and Inspection** · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **Oxygen transfilling room door inspected and added to the Annual Fire/Smoke door Inspections.** · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **All residents have the potential to be affected by the alleged deficient practice.** · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	05/09/2023

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	NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all occupants. Findings include: Based on record review on 04/19/23 at 10:53 a.m. with the Maintenance Director, the document entitled "Logbook Documentation Task name: Annual Fire/Smoke door Inspections" dated 07/15/2022 did not include an inspection of the door to the oxygen transfilling room door. Based on observation during the tour between 12:30 a.m.		**Oxygen Transfilling Room added to Door Inspection Log** **Maintenance Director educated via written communication on expectation to inspect door and that all doors are listed on Door Inspection Log.** · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **Doors Inspection Log to be reviewed with IDT team weekly x4, Monthly x 6 quarterly thereafter.** · by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. **5/9/2023**	

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	and 2:00 p.m., there was an oxygen transfilling room located within the facility. Based on interview at the time of records review, the Maintenance Director agreed that an annual inspection of the door to the oxygen transfilling room had not been completed during the last documented door inspection for the facility. This item was again discussed at the exit conference with the Maintenance Supervisor held on 04/19/23 at 2:30 p.m. 3.1-19(b)			