STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 01 B. WING	11/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/05/12 Facility Number: 009569 Provider Number: 155628 AIM Number: 200139920 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Briarwood Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 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 II (111) construction and fully sprinklered except for the north and south patio exterior canopies. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the	K0000		

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 113 and had a census of 85 at the time of this visit. All areas where residents have customary access were sprinklered, except for the north and south patio exterior canopies. The facility has two detached buildings providing facility supply storage services which were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/08/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4			
	Based on observation and interview, the facility failed to ensure openings through 2 of 5 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 58 residents, staff or visitors in the vicinity of the smoke barrier wall in the South Wing and 10 residents, staff and visitors between the main entrance reception area and the corridor leading to the 300 Hall. Findings include:	K0025	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law.1. Mortar and fire chalking was applied to the openings of the 2 smoke barriers in order to maintain the smoke resistance of each barrier.1a. 58 residents could have been affected by the openings in 2 of the smoke barriers. 1b. The Maintenance Supervisor will inspect the attic monthly to ensure no breaches have occured.1c. Results of the monthly inspections will be documented on the facility's TEL's System. Results of the inspections will be presented to the Quality Assurance Committee monthly.1d. Corrections completed by December 5,	12/05/2012

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	Based on observations with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 11/05/12, the following was noted: a. The smoke barrier wall in the attic above the corridor in the South Wing had a square access door in the wall measuring three feet by two feet which was in the fully open position. b. The attic smoke barrier wall above the corridor from the 300 Hall to the main entrance reception area had three openings which were not firestopped. The openings not firestopped consisted of the annular space surrounding a one inch diameter plastic pipe, a rectangular opening which measured one inch high by four inches long and a three inch in diameter opening in which five cables were passed through the opening. Based on interview at the time of the observations, the Director of Maintenance acknowledged the smoke barrier wall in the attic above the corridor in the South Wing had an open access door in the smoke wall and the aforementioned openings were not firestopped. 3.1-19(b)		20122.The smoke barrier wall in the attic above the corridor in the south wing had an open aceess door in the wall and the afore mentione door had been left open at the time of inspection. The door was closed.2a. 10 residents, staff and visitors between the main entrance reception area and the corridor leading to the 300 hall had the potential to be affected.2b.The maintenance supervisor will continue to do monthly inspections to assure the door is closed and will record this monthly inspection on the facilities TEL's System. If there has been an occurance of fire department workman etc. being in the attic the Maintenance Supervisor will do a follow up check of all open access doors of the smoke walls to ensure they are closed.2c.Results of the scheduled monthly inspection and follow-up when the fireman or any workman have been in the attic will be presented to the Quality Assurance Committee.2d. Date of compliance December 5, 2012	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 says 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. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 58 residents, staff and visitors needing to exit the facility from the South Dining Room exit. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 11/05/12, the South Dining Room exit was marked as a facility exit, the exit door was magnetically locked and could be opened	K0038	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law.1. The code to the lock has been placed above the door on the door frame in the south dining room.1a. 58 residents, staff and visitors needing to exit the facility from the south dining room exit have the potential to be affected.1b. The Maintenance Supervisor will inspect all doors to ensure codes are present.1c. Results of the monthly inspections will be documented on the facility's TEL's System. Results of the inspection will be presented to the Quality Assurance Committee monthly.1d. Date of compliance December 5, 2012.2.The alarm company was called immediately and they reactivated the electromagnetic lock on the facility door by room 310.2a. 20 residents had the potential to be affected by the electromagnetic lock not releasing.2b. The Maintenance Supervisor will inspect all doors to ensure they release and unlock during the	12/05/2012

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	by entering a four digit code but the code was not posted. Based on interview with the Maintenance Supervisor at the time of observation and with the Administrator during the exit conference at 1:50 p.m. on 11/05/12, approximately 50 %, or more, of the residents utilizing the aforementioned exit location do not have a clinical diagnosis to be in a secure building and acknowledged the exit code was not posted at the South Dining Room exit. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 7 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2(e) requires doors with special locking arrangements such as electromagnetic locks to unlock upon activation of the building sprinkler or fire detection system and shall remain unlocked until the fire protective signaling system has been manually reset.		monthly fire drills.2c.Results of the monthly inspection of the electromagnetic locks will be documented on the Facility's TEL's System. Results will be presented to the Quality Assurance Committee monthly.2d. Date compliance December 5, 2012.	

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	This deficient practice could affect 20 residents, staff and visitors needing to exit the facility by Room 310. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 11/05/12, the electromagnetic lock on the facility exit door by Room 310 did not release and remain unlocked when the fire alarm was activated at 1:18 p.m. Based on interview at the time of observation, the Director of Maintenance acknowledged the electromagnetic lock on the facility exit door by Room 310 did not release and remain unlocked when the fire alarm was activated. 3.1-19(b)			

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K0052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.2.5.2 states connections to the light and power service shall be on a dedicated branch circuit(s). Circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. The location of the circuit disconnecting means shall be permanently identified at the fire alarm control unit. NFPA 72, 1-5.2.5.3 states an overcurrent protective device of suitable current carrying capacity and capable of interrupting the maximum short circuit current to which it may be subject shall be provided in each ungrounded conductor. The overcurrent protective device shall be enclosed in a locked or sealed cabinet located immediately adjacent to the point of connection to the light and power conductors. This deficient practice could affect all residents, staff and visitors.	K0052	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law.1. The fire alarm system breaker has been painted red. The breaker has been identified as the FIRE ALARM CIRCUIT CONTROL.2. All residents, staff and visitors had the potential to be affected.3. The Maintenance Director will monitor monthly that the sign (Fire Alarm Circuit Control) and red color is in place. 4. TheMaintenance Supervisor will conduct monthly inspections and information will be documented on the facility's TEL's System. Results of the inspections will be submitted to the Quality Assurance Committee monthly.5. Date of compliance December 5, 2012.	12/05/2012

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	Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 11/05/12, the fire alarm system breaker could not be identified or located. Based on interview at the time of observation, the Director of Maintenance acknowledged the fire alarm system breaker could not be identified or located. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide sprinkler coverage for 2 of 3 combustible exterior canopies each wider than 4 feet on the east side of the facility. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect all residents, staff and visitors needing to exit the building from the North and South Dining Rooms. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 11/05/12, the exterior canopy above the patios outside the North Dining Room	K0056	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law.1. Sprinkler coverage has been installed for the exterior canopy above the patios outside the south dining room exit and outside the north dining room exit.2. All residents, staff and visitors needing to exit the building from the north and south dining room have the potential to be affected. 3. The Maintenance Supervisor will tour the grounds weekly and assure all exterior canopies and exterior roofs wider than 4 feet will have sprinkler coverage.4. Results of the weekly inspection for the	12/05/2012

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	exit and outside the South Dining Room exit each extended 69 inches (five feet nine inches) from the building, was of wood construction and was not provided with automatic sprinklers. Based on interview at the time of the observations, the Director of Maintenance acknowledged each exterior canopy at the North and South Dining Room exits extended more than four feet from the building, was of wood construction and was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)		presence of sprinkler coverage will be documented on the facility's TELs's System. Results of the inspections of the sprinkler coverage will be presented to the Quality Assurance Committee monthly.5. Date of compliance December 5, 2012.	