STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155362	A. BUILDING -- B. WING	09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - MERRILLVILLE CARE CENTER	8800 VIRGINIA PLACE MERRILLVILLE, IN 46410

(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: 09/13/22 Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660 At this Emergency Preparedness survey, Brickyard Healthcare - Merrillville 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 164 certified beds. At the time of the survey, the census was 129. Quality Review completed on 09/14/22	E 0000		
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: 09/13/22 Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660 At this Life Safety Code survey, Brickyard	K 0000		

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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	Healthcare - Merrillville 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 V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are provided with battery powered smoked detectors. The facility is partially protected by a 85 kW Natural Gas generator. The facility has the capacity for 164 and had a census of 129 at the time of this survey. Quality Review completed on 09/14/22			
K 0351 SS=B Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed			

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	6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 laundry rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff in the laundry room. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 11:40 a.m. to 1:00 p.m. on 09/13/22, the escutcheon for a sprinkler on the ceiling in the laundry room was not flush with the ceiling which exposed the attic above. Based on interview at the time of the observation, the Maintenance Director agreed the aforementioned ceiling mounted sprinkler escutcheon was not installed flush with the ceiling which exposed the attic above. Based on observation prior to survey exit, the escutcheon for the sprinkler was fixed and the attic above was no longer exposed. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)	K 0351	Facility is requesting desk/paper compliance Life Safety plan of Correction – Visit date -9/13/2022 K 351 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; for a sprinkler identified in laundry room was identified as not being flush with the ceiling which exposed the attic above 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; No residents were identified as being affected by the deficient practice, but could affect staff in the laundry area, the area was repaired while the surveyor was in the building what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All sprinklers were assessed, and no sprinklers were deficient, the	09/30/2022

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			area was repaired immediately 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 The Maintenance Director/designee will audit all and sprinklers with 1 full audit and the issue will be tracked in building engines quarterly thereafter in perpetuity. This will be reported as a life safety issue and results of building engines audits no less than quarterly in QAPI, any trends will be identified, any trends will be identified until 95 % compliance is reached. 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. The date of correction is 9/30/2022	
K 0353 SS=E 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			

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	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			
	Based on observation and interview, the facility failed to ensure at least 6 of over 200 sprinkler heads in the facility were maintained. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.5 requires glass bulb sprinklers shall be replaced if the bulbs have emptied. This deficient practice could affect up to 46 residents, as well as staff and visitors of C Wing if required to exit through the southwest and northwest exit doors. Findings include: Based on observations on 09/13/22 from 11:40 am to 1:00 p.m. during a tour of the facility with the Maintenance Director, sprinklers heads under the overhang outside C Wing's southwest and northwest exit were glass bulb type sprinkler heads. At least 6 of the sprinkler heads were empty with no color in the glass bulb. Sprinkler heads under the overhang of the northeast exit had a green color in the bulb. Based on interview at the time of observations, the Maintenance	K 0353	Facility is requesting desk/paper compliance K353 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 6 Sprinkler heads under the overhang outside C-Wing exits were empty with no color in the glass bulb and needed to be replaced 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; 46 residents, as well as staff and	09/30/2022

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	Director agreed the sprinkler heads under the southwest and northwest exit overhang were empty with no color in the glass bulbs. This finding was reviewed with the Executive Director and the Maintenance Director at the exit conference. 3.1-19(b)		visitors of C-Wing if required to exit through those doors had the potential to be affected by the 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 sprinklers were examined and were found to be functioning. The 6 were identified and an outside Company made repairs 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 The Maintenance director/designee will audit 1 full audit and the issue will be tracked in building engines quarterly thereafter in perpetuity. This will be reported as a life safety issue and results of building engines audits to QAPI no less than quarterly, any trends will be identified until 95 % compliance is reached. 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. The date of correction is 9/30/2022	
K 0363 SS=B Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors			

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	meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 46 residents, staff and visitors in the vicinity of C Wing dining room. Findings include: Based on observation with the Maintenance Director and Executive Director during a tour of the facility from 11:40 a.m. to 1:00 p.m. on 09/13/22, the corridor double door set serving as the entrance to the C Wing dining room were prevented from closing due to the coordinator not functioning properly. When closed, an approximately two inch gap was present between the meeting edge of the door set. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned corridor door set did not close when tested several times and stated the coordinator needs tightened. Based on observation prior to survey	K 0363	Facility is requesting desk/paper compliance K363 what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke 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; This deficient practice could affect 46 residents, staff and visitors in the vicinity of C-Wing dining room	09/30/2022

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	exit, the door set did successfully close and latch into the frame. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The door has been repaired. All doors had been checked with the surveyor for compliance and were rechecked by the maintenance director for compliance. 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 The Maintenance director/designee will complete one full audit and the issue will be added to building engines daily interior rounds (daily). This will be reported as a life safety issue to QAPI no less than quarterly, any trends will be identified until 95 % compliance is reached. 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.	

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			The date of correction is 9/30/2022 ul="" role="list"	