| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155076 | A. BUILDING -- B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - BROOKVIEW CARE CENTER | 7145 E 21ST STREET INDIANAPOLIS, IN 46219 |

| (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 |
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| E 0000<br><br>Bldg. -- | A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 08/10/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 10/07/22<br><br>Facility Number: 000031<br>Provider Number: 155076<br>AIM Number: 100266150<br><br>At this PSR survey to the Emergency Preparedness survey, Brickyard Healthcare-Brookview Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 136 certified beds. At the time of the survey, the census was 79.<br><br>Quality Review completed on 10/07/22 | E 0000 | We are respectfully asking for a desk review of these findings | |
| K 0000<br><br>Bldg. 01 | A PSR survey to the Life Safety Code Recertification and State Licensure Survey conducted on 08/10/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 10/07/22<br><br>Facility Number: 000031<br>Provider Number: 155076 | K 0000 | We are respectfully asking for a desk review of these findings | |

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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| | 155076 | A. BUILDING 01<br>B. WING | 10/07/2022 |

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| | AIM Number: 100266150<br><br>At this PSR survey, Brickyard Healthcare-Brookview 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.<br><br>This facility, with the east and west wing consisting of one story and the subacute wing consisting of two stories and a basement, 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 all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. All resident sleeping rooms were surveyed. The facility has a capacity of 136 and had a census of 79 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. The facility has one detached shed providing facility storage services which was not sprinklered.<br><br>Quality Review completed on 10/07/22 | | | |
| K 0211<br>SS=E<br>Bldg. 01 | NFPA 101<br>Means of Egress - General<br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. | | | |

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| | 18.2.1, 19.2.1, 7.1.10.1<br>Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 1 of 9 means of egress. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility.<br><br>Findings include:<br><br>Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:20 a.m. to 9:45 a.m. on 10/07/22, the bottom of the west door in the exit door set to the outside of the facility which is nearest the emergency generator was stuck on the threshold under the door and would not release to allow the door to open. Both doors in the exit door set were marked with the necessary signage for delayed egress doors. The east door in the door set released to open after pushing for 15 seconds. The west door did not release to open because it was stuck on the threshold. The Executive Director used a hammer and chisel under the door to force the door to open, but it would not release to open following multiple attempts to open the door unless the hammer and chisel were used to force it open. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the west door in the aforementioned means of egress was not free from obstructions.<br><br>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>This deficiency was cited on 08/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence. | K 0211 | All items have been removed that were blocking any means of egress throughout the building. A daily walkthrough will be conducted 5 days per week and will be entered into Building Engines. The rounds will be conducted by Maintenance Director and or Designee to ensure all means of egress are not blocked.<br>All staff will be educated on the completion of a weekly audit to ensure all means of egress are not blocked including but not limited to dating the inspection. Audits to be completed by Maintenance Director or designee on an ongoing basis.<br><br>Maintenance Director or designee to audit to ensure all means of egress are not blocked. Audits will be taken to the QAPI meeting at least on a quarterly basis. | 10/29/2022 |

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| K 0372 SS=F Bldg. 01 | 3.1-19(b)<br><br>NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>Based on observation and interview, the facility failed to ensure openings through 1 of 2 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff, and visitors.<br><br>Findings include: | K 0372 | The smoke barrier in the mechanical room was repaired and the ceiling penetrations are smoke resistant. The materials used to seal the ceiling penetrations are appropriate. Documentation such as a Product Data Sheet or product label will be maintained.<br>All the residents, staff and visitors have the potential to be affected.<br><br>The smoke barrier in the mechanical room was repaired and the ceiling penetrations are smoke resistant. The materials used to seal the ceiling penetrations are appropriate. Documentation such as a Product Data Sheet or product label will be maintained. | 10/29/2022 |

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| | Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 9:20 a.m. to 9:45 a.m. on 10/07/22, a three inch in diameter hole was noted in the ceiling of the main Mechanical Room which contained the facility's main fire alarm system panel. A two inch in diameter gray conduit penetrated the hole in the ceiling. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hole in the ceiling smoke barrier was not protected to maintain the fire resistance rating of the ceiling smoke barrier.<br><br>This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference.<br><br>This deficiency was cited on 08/10/22. The facility failed to implement a systemic plan of correction to prevent recurrence.<br><br>3.1-19(b) | | The Maintenance Director or designee will audit the building for smoke barriers on a quarterly basis and will enter the information into Building Engines. The center will have the proper caulking and appropriate materials to cover the gaps. Maintenance Director or designee will audit the smoke barriers on an ongoing basis. The audits will be taken to the QAPI meeting at least on a quarterly basis for review. | |