STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155686	A. BUILDING -- B. WING	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - KNOX CARE CENTER	300 E CULVER RD KNOX, IN 46534

(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: 11/30/22 Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260 At this Emergency Preparedness survey, Brickyard Healthcare - Knox 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 a capacity of 57 and had a census of 48 at the time of this survey. Quality Review completed on 12/01/22	E 0000	At this Emergency Preparedness survey, Brickyard Healthcare - Knox 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 a capacity of 57 and had a census of 48 at the time of this survey. Quality Review completed on 12/01/22	
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: 11/30/22 Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260 At this Life Safety Code survey, Brickyard Healthcare - Knox Care Center was found not in compliance with Requirements for Participation in	K 0000	At this Emergency Preparedness survey, Brickyard Healthcare - Knox 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 a capacity of 57 and had a census of 48 at the time of this survey. Quality Review completed on 12/01/22	

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

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	155686	A. BUILDING 01 B. WING	11/30/2022

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	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 III (211) construction and was fully sprinklered. The facility has a monitored fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms contained battery-operated smoke detectors. The facility has a capacity of 57 and had a census of 48 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/01/22			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in			

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	REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 2 laundry room doors which is a hazardous area containing combustible storage and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could staff in the service hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 11/30/22 between 12:40 p.m. and 2:00 p.m., the laundry room, a hazardous storage room and containing fuel-fired equipment, was larger than 50 square feet, was equipped with self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the room contained combustible storage, larger than 50 square feet, and concurred the door would not latch into the frame.	K 0321	Plan of Correction Text: 1. No residents were identified as being directly affected by this deficiency.¿ Door closure for laundry room, has been adjusted by maintenance director to close and latch per regulations. 2. All Residents are potentially affected by this deficient practice. Door closure for laundry room has been adjusted by maintenance director to close and latch per regulations. 3. Maintenance director will audit all doors that require automatic closures to ensure compliance weekly x 4 weeks, then monthly x 6 months. Any deficiencies will be fixed at of identification. 4. Maintenance director will present findings of his audits	12/23/2022

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	Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		monthly x 6 months to the Quality Assurance Performance Improvement. 5. Identified deficiencies will be rectified by 12/23/22	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation, record review and interview, the facility failed to maintain 1 of 1 kitchen commercial cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) as required	K 0324	Plan of Correction Text: 1. No residents were identified as being affected by this deficiency. hydrostatic test for Kitchen Suppression system completed on 12/12/22. 2. All are potentially	12/23/2022

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	by NFPA 101, Life Safety Code (2012), Section 9.2.3. NFPA 96, Section 10.2.6 states that automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and NFPA 17A(09), Standard for Wet Chemical Extinguishing Systems where applicable. This deficient practice could affect all kitchen staff. Findings include: Based on record review with the Maintenance Director on 11/30/22 between 9:07 a.m. and 12:43 p.m., The Kitchen Suppression System Inspection dated 9/27/22 stated that the kitchen suppression system was due for a 12-year hydrostatic test. This was also stated in the Kitchen Suppression System Inspection from 3/17/22. An email was produced from the inspection company stating hardships with obtaining parts for inspection has delayed testing. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		affected by this alleged deficiency.¿ hydrostatic test for Kitchen Suppression system inspection completed on 12/12/22. 3. Maintenance director will monitor kitchen equipment weekly x 4 weeks for inspection compliance, and monthly thereafter to ensure continued compliance. Any concerns will be addressed at of discovery. 4. Maintenance director will present his weekly audits x 1 month, and his monthly audits x 6 months to the Quality Assurance Performance Improvement Meeting. 5. Identified deficiencies will be rectified by 12/23/22.	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s).			

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	Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish on corridor walls on 1 of 1 floors met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect 40 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 11/30/22 between 12:40 p.m. and 2:00 p.m., wood paneling was used as an interior finish in the housekeeping storage room and boiler room. Based on record review between 9:07 a.m. and 12:40 p.m., documentation for a fire resistant treatment was available, but the place and time of application was not documented. Based on interview at the time of record review, the Maintenance Director stated they did not know	K 0331	Plan of Correction Text: 1. No residents were identified as being affected by this deficiency. Identified wood paneling will be treated with fire retardant coating to ensure compliance. 2. All are potentially affected by this alleged deficiency. Identified wood paneling will be treated with fire retardant coating that is rated for wood (document attached) by 12/23/22. 3. Maintenance director will monitor weekly to ensure materials used as interior finishes meet requirements for fire safety rating. The maintenance director will monitor monthly thereafter to ensure continued compliance. Any concerns will be addressed at of discovery. 4. Maintenance director will present his weekly audits x 1 month, and his monthly audits x 6 months to the Quality Assurance Performance Improvement Meeting. 5. Identified deficiencies will be rectified by 12/23/22	12/23/2022

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	whether the paneling was treated with the provided treatment. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0345 SS=C 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 maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel on 11/30/22 at 12:57 p.m., during a tour of the facility with the Maintenance Director, the time on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the date and time to be 11/30/22 at 15:03 p.m. Based on interview at the time of	K 0345	Plan of Correction Text: 1. No residents were identified as being directly affected by this deficiency. was reset proper date and time for fire panel. 2. All residents were potentially affected by this deficiency. was reset proper date and time for fire panel. 3. Maintenance director will inspect fire panel weekly x 4 weeks and monthly times 6 months to ensure continued compliance. Any deficiencies will be addressed at of discovery.	12/23/2022

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	observation, the Maintenance Director indicated he was unaware of the deficiency and would contact the fire alarm company to correct the issue. This finding was reviewed with the Maintenance Director and Administrator at the exit conference.		director will present of his audits monthly x 6 months to the Quality Assurance Performance Improvement. 5. Identified deficiencies will be rectified by 12/23/2020.	
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 automatic sprinkler systems 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, 2011 Edition, Section 5.1.1.1.3 states sprinklers manufactured using	K 0353	Plan of Correction Text: 1. No residents were identified as being directly affected by this deficiency. Quick response sprinkler heads were identified as needing testing, wires were identified as resting on a sprinkler line and sprinkler head cabinet was identified as not large enough	03/06/2023

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	fast-response elements that have been in service for 20 years shall be replaced, or representative samples shall be tested and then retested at 10-year intervals. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review of the Sprinkler System Inspection documentation on 11/30/22 between 9:07 a.m. and 12:40 p.m., the report stated that the sprinkler heads were less than 50 years old, however the facility did not have documentation if any of the quick response sprinkler heads have ever been tested. Based on interview at the time of record review, the Maintenance Director stated he had no knowledge whether the sprinkler heads have been tested or not. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all		to contain all extra sprinkler heads. 2. 20 residents on the east wing were identified as potentially affected by this deficiency. Safe Care is scheduled on 1/5/22 to evaluate and send for testing our Quick Response Sprinkler heads. Sprinkler heads will be sent for testing on 1/6/23. Results of testing could take up to 60 days. A waiver has been requested to allow time for testing and implementation of any necessary plan to rectify. Facility will address any identified issues when notified of results (letter attached). Wires resting on sprinkler line were rerouted to not rest on sprinkler lines. head storage cabinet was adapted to accommodate additional spare sprinkler heads. 3. Maintenance director will inspect sprinkler heads and sprinkler lines weekly x 4 weeks and monthly times 6 months to ensure continued compliance. Any deficiencies will be addressed at of discovery. Maintenance director will present results of his audits monthly x 6 months to the Quality Assurance Performance Improvement. 5. Identified deficiencies will be rectified by 3/6/2023.	

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	automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 11/30/22 between 12:40 p.m. and 2:00 p.m., the smoke barrier next to room 29 contained electrical wires being supported by a sprinkler line. Based on interview at the time of observation, the Maintenance Director agreed wires were being supported by a sprinkler line and would correct the issue. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 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			

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	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 11/30/22 between 1:05 p.m. and 2:00 p.m., the spare sprinkler cabinet in the riser room was not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinet in riser room was opened, the cabinet contained four more sprinkler heads than spots available. Based on interview at the time of the observations, the Maintenance Director agreed the cabinet was not large enough to contain all spare sprinkler heads. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)			
K 0363 SS=D 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			

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	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 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 25 resident room corridor doors on the southwest wing was 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 2 residents in room 25.	K 0363	Plan of Correction Text: 1. 2 residents in room 25 were identified as being directly affected by this deficiency.¿ for room 25 has been adjusted by the maintenance director to close and latch per regulations.	12/23/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - KNOX CARE CENTER	300 E CULVER RD KNOX, IN 46534

(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
	Findings include: Based on observation with the Maintenance Director on 11/30/22 between 12:40 p.m. and 2:00 p.m., the corridor door to resident room 25 did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed that the door would not latch when closed. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		2. All Residents are potentially affected by this deficient practice. Doors for resident rooms have been inspected by maintenance director to close and latch per regulations, no other areas of concern identified. 3. Maintenance director will audit all resident room doors to ensure compliance weekly x 4 weeks, then monthly x 6 months. Any deficiencies will be fixed at of identification. 4. Maintenance director will present findings of his audits monthly x 6 months to the Quality Assurance Performance Improvement. 5. Identified deficiencies will be rectified by 12/23/22.	
K 0500 SS=B Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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 ensure 1 of 4 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA	K 0500	Plan of Correction Text: 1. No residents were identified as being directly affected by this deficiency.¿ Boiler Inspection	12/23/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155686	A. BUILDING 01 B. WING	11/30/2022

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	101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff in the boiler room and housekeeping storage area. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 11/30/22 between 12:40 p.m. and 2:00 p.m., the water heater in the main boiler room did not have an up-to-date certificate of inspection. The only certificate had an expiration date of 2018. Based on interview at the time of the observation, the Maintenance Director stated the inspector came recently, but was unable to provide documentation for an updated inspection. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		certificate received and is valid until 5/21/23. 2. No Residents are potentially affected by this deficient practice. Boiler Inspection certificate received and is valid until 5/21/23. No other areas of concern identified. 3. Maintenance director will audit all boilers for compliance weekly x 4 weeks, then monthly x 6 months. Any deficiencies will be fixed at of identification. 4. Maintenance director will present findings of his audits monthly x 6 months to the Quality Assurance Performance Improvement. 5. Identified deficiencies will be rectified by 12/23/22.	