STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155375	A. BUILDING -- B. WING	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - PETERSBURG CARE CENTER	309 W PIKE AVE PETERSBURG, IN 47567

(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: 08/21/24 Facility Number: 000033 Provider Number: 155375 AIM Number: 100266280 At this Emergency Preparedness survey, Brickyard Healthcare-Petersburg 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 86 certified beds and had a census of 44 at the time of this visit. Quality Review completed on 08/23/24	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: 08/21/24 Facility Number: 000033 Provider Number: 155375 AIM Number: 100266280 At this Life Safety Code survey, Brickyard	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Eckert	Executive Director	08/30/2024

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-Petersburg 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 detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 44 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services were sprinklered except: 1. A thirty foot by eighteen foot detached garage constructed of wood framing and metal covering and storing maintenance supplies and kitchen equipment 2. A fifteen foot by twelve foot detached portable wood shed storing paper records 3. A twelve foot by nine foot detached wood shed storing the facility's water softener. Quality Review completed on 08/23/24			
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,			

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	155375	A. BUILDING 01 B. WING	08/21/2024

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	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 1 of 1 fire department connection was in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observations on 08/21/24 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the facility's fire department connection	K 0353	Facility is requesting paper compliance for this alleged deficiency. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: FDC signage was purchased and installed above the facility's fire department connection. How other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Signage installed above the facility's fire department connection. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Director of Maintenance/Designee	08/28/2024

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	(FDC) was located on the east side of the facility. There was no FDC signage provided at the fire department connection for the responding fire department to lead them to the FDC for easy identification. Based on interview at the time of observation, this was acknowledged by the Maintenance Director who agreed there should be FDC signage at the FDC. This finding was reviewed with the Executive Director, Maintenance Director, and Maintenance Assistant during the exit conference. 3.1-19(b)		to monitor for continued placement of signage. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: Director of Maintenance /Designee to monitor weekly for 4 weeks, monthly for 5 months, then quarterly as needed.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage room where oxygen transfilling takes place, was provided with properly working mechanical ventilation. This deficient practice could affect mostly staff in the southeast corridor, plus residents in the Therapy room. Findings include:	K 0927	Facility is requesting paper compliance for this alleged deficient practice. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: New vented exhaust fan installed	08/28/2024

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	Based on observations on 08/21/24 between 11:45 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Director and Maintenance Assistant, the oxygen storage/transfilling room was equipped with a mechanically vented exhaust fan, however, it was not working at the time of observation. Based on interview at the time of observation, the Maintenance Director agreed the mechanically vented exhaust fan was not working. This finding was reviewed with the Executive Director, Maintenance Director, and Maintenance Assistant during the exit conference. 3.1-19(b)		in room. How other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken. All residents have the potential to be affected by the alleged deficient practice. Monitoring of vented exhaust fan for proper working order. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Director of Maintenance/Designee to monitor for continued working exhaust fan. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: Director of Maintenance/Designee to monitor weekly for 4 weeks, monthly for 5 months, then quarterly as needed.	