STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING -- B. WING	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - TWELFTH STREET CARE CENTE	811 E 12TH STREET MISHAWAKA, IN 46544

(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: 10/07/24 Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400 At this Emergency Preparedness survey, Brickyard Healthcare - Twelfth Street 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 87 certified beds. At the time of the survey, the census was 66. Quality Review completed on 10/08/24	E 0000	**Brickyard 12th St Care Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/07/24 Facility Number: 000045 Provider Number: 155109 AIM Number: 100291400 At this Life Safety Code survey, Brickyard Healthcare - Twelfth Street Care Center was found	K 0000	**Brickyard 12th St Care Center please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Cardoso	Administrator	10/21/2024

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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	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. The one-story facility constructed in 1965 and 1966 was determined to be of Type IV (2HH) construction and fully sprinklered. The 1986 one story therapy addition was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in spaces open to the corridors. Battery powered smoke detectors are provided all resident sleeping rooms. The building is fully protected by a 100-kW diesel powered generator. The facility has a capacity of 87 and had a census of 66 at the time of the survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except an unsprinklered garage and storage shed. Quality Review completed on 10/08/24			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door	K 0222	**K222** 1 A delayed egress sign was added to the door indicating the doors can be opened in 15 seconds by pushing on the door. 2 All residents in the area have the potential to be affected by the alleged deficient practice. A	10/21/2024

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	leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect approximately 25 residents and staff. Findings include: Based on observation during tour of the facility with the Maintenance Director on 10/07/24 between 12:37 p.m. and 1:37 p.m., the marked emergency exit door located in the back hallway, next to the kitchen, was provided with delayed egress locks but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. The finding was discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		delayed egress sign was added to the door indicating the doors can be opened in 15 seconds by pushing on the door. 3 A weekly recurring task "doors, locks, and alarms" was added to TELS to check the delayed egress doors for proper signage. 4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. 5 Date corrections completed: 10/21/24	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all	K 0353	**K353** 1 Quarterly sprinkler inspections will be completed in the proper time frame within the quarter going forward. 2 All residents have potential to be affected by the alleged deficient practice. Quarterly sprinkler inspections will be completed in the proper time frame within the quarter going forward.	11/01/2024

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	inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Maintenance Director on 10/07/24 between 10:48 a.m. and 12:27 p.m., there was no quarterly sprinkler system inspection report available for the third quarter (July, August & September) of 2024. Based on further review, two fourth quarter (October, November & December) had been documented. One was completed in December 2023 and one dated October 2024. During an interview at the time of record review, the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system had been inspected during the third quarter of 2024 and stated that the facility had rescheduled the sprinkler inspection due to state survey because they did not want the inspections to interrupt the survey. Meaning, the third quarter inspection was pushed into the fourth quarter.		3 A Task sprinkler inspection task was added to TELS to indicate the inspection is due. 4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. 5 Date corrections completed:11/1/24	

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	The finding was reviewed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 24 resident room corridor doors on the 200-Hall wing 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 approximately 30 residents and staff. Findings include: Based on observation with the Maintenance Director on 10/07/24 between 12:37 p.m. and 1:37 p.m., the corridor door for the linen closet, across from resident room 226, had latching hardware, however the latching device within the door was stuck which would not let the hardware operate correctly. When the door closed, the door would not latch into the frame after testing three times. Furthermore, the door to resident room 211 did not latch into the frame after testing three times. Based on interview at the time of observation, the Maintenance Director confirmed that the door would not latch and further stated that he would have to take a look at the doors so they can be fixed. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K363** 1 The corridor door for the linen closet, across from resident room 226, had latching hardware repaired to effectively latch into the frame. The door to resident room 211 was repaired to effectively latch into the frame. 2 All residents in the areas adjacent to these doors have potential to be affected by the alleged deficient practice. The corridor door for the linen closet, across from resident room 226, had latching hardware repaired to effectively latch into the frame. The door to resident room 211 was repaired to effectively latch into the frame. 3 A monthly “door latch check” was added to TELS to check proper latching of doors. 4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. 5 Date corrections completed:10/8/24	10/08/2024

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions for all shifts for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the Maintenance Director on 10/07/24 between 10:40 a.m. and 12:27 p.m., fire drills were being completed at the end of the month. Three fire drills within the four quarters were each conducted on the 31st then on the 27th. Furthermore, two fire drills were completed on the 28th and the 18th of a month for two quarters. Based on interview at the time of record review, the Maintenance Director acknowledged that the dates of the fire drills had been completed at the end of each month and further stated that he just conducted the fire drills at random times and did not realize the dates were repeating. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	**K712** 1 The maintenance director will ensure drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift by holding drills during differing times of the month. 2 The alleged deficient practice could potentially affect all residents. The maintenance director will ensure drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift by holding drills during differing times of the month. 3 An inspection was added to TELS quarterly for each shift in rotation to ensure a drill is conducted once per shift per quarter. Maintenance was trained to conduct drills at differing dates throughout the month on each shift to ensure drill is random to participants. 4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. 5 Date corrections completed:10/21/24	10/21/2024
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and	K 0761	**K761**	10/08/2024

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	interview, the facility failed to ensure annual inspection and testing of 2 of 2 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.		1 An annual inspection for the (2) fire door assemblies for both oxygen storage/transfilling room was conducted. 2 All residents have potential to be affected by the alleged deficient practice. An annual inspection for the (2) fire door assemblies for both oxygen storage/transfilling room was conducted. 3 The (2) fire door assemblies for both oxygen storage/transfilling rooms were added to TELS for an annual inspection along with the other facility fire doors. 4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. 5 Date corrections completed:10/08/24	

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	(7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect approximately 40 residents and staff. Findings include: Based on record review with the Maintenance Director on 10/07/24 between 10:48 a.m. and 12:27 p.m., no documentation of an annual inspection for the (2) fire door assemblies for both oxygen storage/transfilling room was available for review. Based on observation during the tour between 12:39 p.m. and 1:37 p.m., there were (2) one and a half hour fire door assemblies in the two oxygen storage/transfilling rooms. Based on interview at the time of record review and observation, the Maintenance Director stated the annual fire door inspection was not completed within the last year. The finding was discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were installed properly and used in a safe manor. NFPA 99,	K 0920	**K920** 1 Within the front nurse's desk, near the main entrance, a	10/09/2024

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	Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 4 staff and an unknown number of residents. Findings include: Based on observation with the Maintenance Director on 10/07/24 between 12:39 p.m. and 1:37 p.m., within the front nurses desk, near the main entrance, a power strip used to power electronic equipment was dangling off the desk and hanging by the power cord in the outlet. Furthermore, a power strip used to power electronic equipment in the education office next to the desk on the back wall was dangling by its power cord. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strips were dangling, not secured, and stated the power strips will need to be mounted or set on the floor. The power strips were placed upon desks during observations and not dangling by the end of the survey. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		power strip used to power electronic equipment was corrected to not be dangling off the desk and hanging by the power cord in the outlet. The power strip used to power electronic equipment in the education office next to the desk on the back wall was corrected to not be dangling by its power cord. 2 All residents adjacent to the areas listed have potential to be affected by the alleged deficient practice. Within the front nurse's desk, near the main entrance, a power strip used to power electronic equipment was corrected to not be dangling off the desk and hanging by the power cord in the outlet. The power strip used to power electronic equipment in the education office next to the desk on the back wall was corrected to not be dangling by its power cord. 3 Staff was trained on proper power strip use. A monthly inspection was added to TELS to check for and correct dangling power strips. 4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. 5 Date corrections completed:10/9/24.	

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K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 2 oxygen transfilling rooms that are separated from any portion of a facility, NFPA 99 2012 edition 11.5.2.3.1, Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. This deficient practice could affect up to 21 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 10/07/24 between 12:39 p.m. and 1:37 p.m., the oxygen storage/transfer room, near the main entrance, contained liquid oxygen tanks, oxygen cylinders, and other oxygen supplies filling the room. The door to the oxygen room was not self-closing. Based on interview at the time of observation, the Maintenance Director acknowledged that the door was not self-closing and further stated that they have an extra closer that can be installed.	K 0927	**K927** 1 For the oxygen storage/transfer room, near the main entrance a door closer was added to ensure the door is self-closing and latches into the frame automatically. 2 All residents in the area have potential to be affected by this alleged deficient practice. For the oxygen storage/transfer room, near the main entrance a door closer was added to ensure the door is self-closing and latches into the frame automatically. 3 A fire door “inspection latch and gap” was added to recur every 6 months which outlines proper fire door requirements including a properly functioning self-closing device. The (2) fire door assemblies for both oxygen storage/transfilling rooms were added to TELS for an annual inspection along with the other facility fire doors which also addresses proper self-closing. 4 Maintenance will report to QAPI no less than quarterly in perpetuity regarding life safety issues. 5 Date corrections completed:10/08/24	10/08/2024

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			