STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155120	A. BUILDING -- B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

(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: 01/30/24 Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170 At this Emergency Preparedness survey, Brickyard Healthcare - Brandywine Care Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 128 certified beds. At the time of the survey, the census was 102. Quality Review completed on 01/31/24	E 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth the survey report. Our Plan of Correction was prepared and executed to continuously improve the quality of care and comply with all applicable federal and state requirements.	
E 0031 SS=C Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Colleen McCreary-Warnick	Executive Director	02/16/2024

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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	plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan included all applicable sources of assistance. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director, Executive Director,	E 0031	E031 Emergency Officials Contact Information What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The contact information for the Ombudsman will be placed in the EPP Binder's tab 1	02/12/2024

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	Executive Director in Training and Director of Nursing on 01/30/24 between 9:45 a.m. and 12:30 p.m., documentation of the communication plan part of the facility's emergency operations plan reviewed did not include specific contact information, including telephone number, for notification of the State Long Term Care Ombudsman. The ED agreed documentation for the communication plan part of the program did not include specific contact information for the office of the State Long Term Care Ombudsman. The contact for the State Long Term Care Ombudsman could not be located in the plan at the time of the survey. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Executive Director, Executive Director in Training and Director of Nursing present.		How be identified and what corrective action will be taken? What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The annual review of the EPP binder is set to be reviewed annually in August in our Direct Supply TELS maintenance work order system and to recur August 2024. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Maintenance will report to QAPI no less than quarterly in perpetuity regarding the life safety tags. By what date be completed? Systemic changes will be completed by 2/12/24.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000	Preparation, submission and	

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/30/24 Facility Number: 000050 Provider Number: 155120 AIM Number: 100266170 At this Life Safety Code survey, Brickyard Healthcare - Brandywine 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 smoke detection in the corridors and areas not separated from the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 128 and had a census of 102 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/31/24		implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth the survey report. Our Plan of Correction was prepared and executed to continuously improve the quality of care and comply with all applicable federal and state requirements.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING			

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	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 2 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 25 residents. Findings include: Based on observation and interview with the Maintenance Director, Executive Director and Executive Director in Training on 01/30/24 between 12:30 p.m. and 3:15 p.m., in the dining area the door to the outside courtyard was not an exit door and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the Executive Director stated the courtyard is not an exit to the public way and acknowledged the courtyard door did not have a "NO EXIT" sign posted. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance	K 0293	K293 Exit Signage What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A new “NOT AN EXIT” sign has been posted on the courtyard doors from the dining room. How be identified and what corrective action will be taken? All residents in the dining room have the potential to be affected by the alleged deficient practice, added TELS task monthly. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A monthly task was added to the TELS system to check all courtyard doors for “NOT AN . This task will remain on TELS. How be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?	02/16/2024

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	Director, Executive Director, Executive Director in Training and Director of Nursing present. 3.1-19(b)		Monthly TELS task was added to ensure signage is in place, maintenance will report to QAPI no less than quarterly in perpetuity regarding the life safety tags. By what date be completed? Systemic changes were completed on 2/16/24.	
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 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 maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25,	K 0353	K353 Sprinkler System-Maintenance and Testing What corrective action will be accomplished for those residents to have been affected by the	02/15/2024

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	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 25 residents in one smoke compartment. Findings include: Based on observation and interview with the Maintenance Director, Executive Director and Executive Director in Training on 01/30/24 between 12:30 p.m. and 3:15 p.m., the attic space above the "Reflections hall" had wire draped across the sprinkler pipe above the ceiling in several locations along the hall. White and Black wire was evident across the sprinkler pipe in several locations along the hall corridor. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Executive Director, Executive Director in Training and Director of Nursing present. 3.1-19(b)		deficient practice? Wiring draped across the sprinkler pipes in the attic will be moved so that it is not supporting the extra weight. How be identified and what corrective action will be taken? Wiring draped across the sprinkler pipes was removed so that it is not supported by the sprinkler system. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? An annual inspection was added to the TELS system and was completed by the facility for a visual inspection of the piping in the attic to ensure no external loads were draped across the sprinkler piping. How be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Any future contract work to be done in the attic space will be monitored during and inspected upon completion to prevent any further deficient tags. Maintenance will report to QAPI no less than quarterly in perpetuity regarding	

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			the life safety tags. By what date be completed? Systemic changes will be completed by 2/15/24.	
K 0363 SS=E 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 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,			

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	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 all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect staff and 15 plus residents. Findings include: Based on observation and interview with the Maintenance Director, Executive Director and Executive Director in Training on 01/30/24 between 12:30 p.m. and 3:15 p.m., the following doors failed to latch positively into their respective door frames: a) Double door set between the kitchen and the dining area. b) Medical Supply Closet next to RR# 34. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Executive Director, Executive Director in Training and Director of Nursing present. 3.1-19(b)	K 0363	K363 Corridor Doors What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The double doors to the kitchen from the dining room and the medical supply closet next to room 34 on the Reflections unit were repaired to latch properly into the frame. How be identified and what corrective action will be taken? A monthly TELS task was added to the maintenance tasks. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A monthly TELS inspection was added to check all door latches in	01/31/2024

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			the facility for proper inspection. This task will remain on TELS. How be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Monthly task added to TELS, maintenance will report to QAPI no less than quarterly in perpetuity regarding the life safety tags. By what date be completed? Systemic changes were completed 1/31/24.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility.	K 0712	K712 Fire Drills What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	02/16/2024

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	Findings include: Based on records review and interview with the Maintenance Director, Executive Director, Executive Director in Training and Director of Nursing on 01/30/24 between 9:45 a.m. and 12:30 p.m., 10 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Executive Director, Executive Director in Training and Director of Nursing present. 3.1-19(b)		Fire drills will be varied to include different times and dates each month. How be identified and what corrective action will be taken? All residents have the potential to be harmed by the alleged deficient practice. A schedule of the dates and times of fire drills has been created. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A schedule will be created to ensure times and dates of the fire remain unpredictable for staffing to ensure drills are at least 2 hours apart during different times each month. How be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Follow the new schedule that will be put in place. Maintenance will report to QAPI no less than quarterly in perpetuity regarding the life safety tags. By what date be completed? Systemic changes will be	

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			completed by 2/16/24.	
K 0927 SS=F 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) 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation and interview with the Maintenance Director, Executive Director and Executive Director in Training on 01/30/24 between 12:30 p.m. and 3:15 p.m., the oxygen trans-filling room had a one-inch hole in the ceiling. Based on an interview at the time of observation, the Maintenance Director agreed there was an unsealed hole in the ceiling of the oxygen trans-filling room.	K 0927	K927 Gas Equipment- Transfilling Cylinders What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The hole in the ceiling in the oxygen room was filled with 4-hour intumescent fire caulk and the “in use” sign was placed on the oxygen room door. How be identified and what corrective action will be taken? A monthly task was added to TELS. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? A task was added to the TELS system for a monthly oxygen room signage and	02/21/2024

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BRICKYARD HEALTHCARE - BRANDYWINE CARE CENTER	745 N SWOPE ST GREENFIELD, IN 46140

(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
	2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect all residents. Findings include: Based on observation and interview with the Maintenance Director, Executive Director and Executive Director in Training on 01/30/24 between 12:30 p.m. and 3:15 p.m., the oxygen storage/transfer room did not have a posted sign making a clear distinction between when transferring of oxygen is occurring in this location and when it is not. Based on interview at the time of observation, the Executive Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director, Executive Director, Executive Director in Training and Director of Nursing present. 3.1-19(b)		construction check to ensure there are no penetrations are present and that the present “in use” sign is present. All nursing staff will be in- on the use of the “in use” signage. How be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? All staff in- to be up to date and all new staff in- going forward. Maintenance will report to QAPI no less than quarterly on perpetuity regarding the life safety tags. By what date be completed? Systemic changes will be completed by 2/21/24.	