STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING -- B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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 Dates: 08/26/24 - 08/27/24 Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130 At this Emergency Preparedness survey, Brickyard Healthcare - Elkhart Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 175 certified beds. At the time of the survey, the census was 112. Quality Review completed on 08/29/24	E 0000	The facility and it's managing partners respectfully request that this Plan of Correction be considered for desk review.	
E 0032 SS=F Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all residents, staff and visitors. Findings include:	E 0032	E 032 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Facility has an Emergency Preparedness Communication plan in place that includes Primary and alternate means for communicating with Facility staff, Federal, State, tribal, regional, and local emergency management	09/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chad Knisley	Executive Director	09/13/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING -- B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	Based on record review and interview with the Executive Director and Maintenance Director from 9:15 a.m. to 12:47 p.m. on 08/26/24, the emergency preparedness communication plan provided did not address primary and alternate means for communication. Based on interview at the time of records review, the Executive Director stated he was not able to locate documentation in the plan for primary and alternate means of communication. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference.		agencies in the event of an emergency. This communication plan was not presented at the time of survey. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be impacted by this deficiency. Education has been provided on location and contents of Emergency Preparedness Manuals for all staff. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff will be re-educated on Emergency Communication Plan. The Executive Director/designee will ensure the Emergency Communication Plan is reviewed upon hire, monthly with all-staff meetings for 6 months and quarterly thereafter. **How will the corrective action(s) be monitored:** Maintenance Director/designee will report to QAPI no less than quarterly to ensure ongoing quality assurance and compliance. **Date of compliance** **9/13/2024**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
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 Dates: 08/26/24 - 08/27/24 Facility Number: 000039 Provider Number: 155685 AIM Number: 100275130 At this Life Safety Code survey, Brickyard Healthcare - Elkhart 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 (000) construction and was fully sprinklered except for the electrical room in the maintenance shop. The original building (North, East and South Units) was constructed in 1968 with an addition (Primrose and Southwest Units) built in 1975. The North Unit has been decommissioned and no longer has residents. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility is protected by a 500-kW diesel generator. The facility has 175 certified beds. At the time of the survey, the census was 112.	K 0000	The facility and it's managing partners respectfully request that this Plan of Correction be considered for desk review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered with the exception of the electrical room in the maintenance shop. Quality Review completed on 08/29/24			
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 more than 20 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 45 residents, staff and visitors. Findings include: Based on observation and interview with the Maintenance Director and Maintenance Assistant during a tour of the facility at 2:40 p.m. on 08/26/24, the exit gate from the main courtyard in the Southwest unit was magnetically locked requiring a code but the code was not posted at the exit. Based on interview, the Maintenance Director stated the codes were posted by all other exits and he would post the code on the Southwest main courtyard gate as well. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit	K 0222	**K 0222** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The exit gate to the main courtyard in the Southwest unit has a code posted at the point of exit. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Audit conducted on egress doors/gates to ensure a code is posted to exit. Any other doors/gates identified will have a code posted. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director educated on posting codes to egress	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	conference. 3.1-19(b)		doors/gates. Preventative Maintenance audit will be added to Building TELS to check egress door/gate codes are posted. **How will the corrective action(s) be monitored:** Maintenance Director/designee will monitor doors to ensure codes are posted daily for 5 days, weekly for 4 weeks and monthly thereafter as part of their Preventative Maintenance program. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved for 3 consecutive months. Results of audits will be adjusted as needed to maintain compliance. **Date of compliance** **9/13/2024**	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of more than 20 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 24 residents, staff and visitors.	K 0293	**K 293** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The South Unit Door to the courtyard is not an Exit. A sign has been posted on the door indicating “This is NO EXIT.” **How will you identify other residents having the potential to be affected by the same deficient practice and what**	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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 and interview with the Maintenance Director and Maintenance Assistant during a tour of the facility at 2:11 p.m. on 08/26/24, the South unit door to the courtyard was not posted with an EXIT sign or a NO EXIT sign. A gate in the courtyard was secured in a manner preventing it from opening. Based on interview at the time of the observation, the Maintenance Director stated he was not aware of missing signage at the door. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference. 3.1-19(b)		**corrective action will be taken?** Exterior Doors have been assessed to ensure doors that are not an exit nor a way of exit are clearly marked so that they are not mistaken for an exit. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director/designee monitor through Preventative Maintenance program in TELS to ensure signage remains in place clearly indicating when a door/passage is “Not an Exit.” **How will the corrective action(s) be monitored:** Maintenance Director/designee will monitor report to QAPI no less than quarterly to ensure quality assurance and compliance. **Date of compliance 9/13/2024**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 front lobbies in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect	K 0351	**K 351** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The escutcheon around the sprinkler head in the front lobby has been repaired to ensure the	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	residents, staff and visitors in 1 of 8 smoke compartments. Findings include: Based on observation and interview with the Maintenance Director and Maintenance Assistant during a tour of the facility from 8:50 a.m. to 10:30 a.m. on 08/27/24, a sprinkler in the front lobby had an escutcheon that did not cover the entire annular space around the sprinkler. A space of approximately one-half inch around the escutcheon was open to the space above the drop ceiling. Based on interview at the time of observation, the Maintenance Director stated he needed to repair the area around the sprinkler. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference. 3.1-19(b)		devise used to cover the annular space around the sprinkler head. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** A complete audit of sprinkler heads has been completed to ensure the escutcheon around the sprinkler head covers the annular space around the sprinkler head. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director/designee to complete a whole house audit of sprinkler head escutcheon plates then quarterly thereafter as part of the Preventative Maintenance program. **How will the corrective action(s) be monitored:** Maintenance Director/designee to one whole house audit of sprinkler head escutcheon plates then quarterly thereafter as part of the Preventative Maintenance program. Results of these audits will be reviewed in QAPI. Results of audits will be adjusted as needed to maintain compliance.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	Based on observation and interview, the facility did not ensure 1 of 1 fire department connections 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 residents, staff and visitors. Findings include: Based on observation and interview with the Maintenance Director and Maintenance Assistant at 1:35 p.m. on 08/26/24, at the facility's front entrance door, the fire department connection (FDC) was located at the side of the front door obscured from view by bush in the landscaping area and not visible from the main roadway. There was no directional signage on the property leading to the FDC. Based on interview, the Maintenance Director stated the FDC would not be seen unless prior knowledge of the location was known. The Maintenance Director stated he planned to remove the bush and provide directional signage from the main parking lot.	K 0353	**K 353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The bush obscuring the view of the Fire Department Connection (FDC) to the Sprinkler System has been removed and directional signage has been posted from the main parking lot to the FDC. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and visitors have the potential to be impacted by this deficiency. The bush obscuring the view of the Fire Department Connection (FDC) to the Sprinkler System has been removed and directional signage has been posted from the main parking lot to the FDC. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director/designee will monitor to ensure exterior shubs/trees do not obscure the view of the FDC from the main roadway 5x/week for 4 weeks and monthly thereafter. **How will the corrective action(s) be monitored:**	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference. 3.1-19(b)		Audits will be conducted monthly based on Preventative Maintenance program. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved for 3 consecutive months. Results of audits will be adjusted as needed to maintain compliance. **Date of compliance** **9/13/2024**	
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulations Based on record review, observation and interview, the facility failed to provide a smoking policy, regulations, or other documentation which included any of the provisions as required by LSC Section 19.7.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from 9:15 a.m. to 12:47 p.m. on 08/26/24, no documented smoking policy could be provided. Based on interview at the time of record review, the Executive Director and Maintenance Director stated the facility has designated smoking areas for staff and residents in the rear area of the building but was not able to produce any documentation stating a policy or facility regulations regarding smoking. Based on observation and interview with the Maintenance Director and Maintenance Assistant during a tour of the facility from 8:50 a.m. to 10:30 a.m. on 08/27/24, three smokers poles were provided;	K 0741	**K 741** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Cigarettes butts have been cleaned from ground in "Designated Smoking Areas" for staff and residents. Signage is posted designating Smoking areas. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents, staff and families have the potential to be impacted by this deficiency. Maintenance Director/designee will conduct an audit around building to ensure there are no smoking butts. Any	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	however, over fifteen cigarette butts were strewn on the ground outside the facility near the Southwest unit exit. Based on interview at the time of observation, the Maintenance Director stated they will clean up the cigarette butts on the ground and properly dispose of them. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference. 3.1-19(b)		defects identified and cleaned immediately. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** All staff will be re-educated on location of Designated Smoking areas and how to dispose of cigarettes. All staff will be re-educated on how to assist residents to ensure cigarettes are disposed of properly. Areas are being monitored and any improper disposal of cigarette butts is being addressed immediately. **How will the corrective action(s) be monitored:** Maintenance Director/designee will report to QAPI no less than quarterly to ensure quality assurance and compliance. **Date of compliance** **9/13/2024**	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on record review and interview, the facility failed to ensure staff were properly trained on transfilling oxygen procedures. NFPA 99 2012 edition, Section 11.5.2.3.1 (4) requires the individual transfilling the container(s) to be properly trained in the transfilling procedures. Section 11.5.2.1.2 states: Health care facilities shall provide programs of continuing education for their personnel. Section 11.5.2.1.3 states: Continuing education programs shall include	K 0927	**K 927** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All direct care staff have been educated to ensure they are properly trained on oxygen safety and oxygen usage and transfilling	09/13/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
	periodic review of safety guidelines and usage requirements for medical gases and their cylinders. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Executive Director and Maintenance Director from 9:15 a.m. to 12:47 p.m. on 08/26/24, documentation titled "Oxygen Safety" was provided which included requirements for continued training; however, no documentation of training conducted was available to indicate that staff who transfill liquid oxygen was properly trained for transfilling. Based on interview, the Executive Director stated he would look for the training documents; however, no documentation was provided. This finding was reviewed with the Maintenance Director and Maintenance Assistant at the exit conference. 3.1-19(b)		to liquid oxygen containers or to portable containers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** This deficiency has the potential to affect all residents, staff and families. All direct care staff have been educated to ensure they are properly trained on oxygen safety and oxygen usage and transfilling to liquid oxygen containers or to portable containers. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Staff Development Director/designee will re-inservice and complete Competency checks for all direct care staff. Staff Development Director/designee will ensure all direct care staff are trained on “Oxygen Safety” and “Oxygen Safety Education Competency” is completed upon hire and during annual Skills Fair. **How will the corrective action(s) be monitored:** Staff Development Director/designee will audit weekly with new hires for 4 weeks, then monthly to ensure education is completed. Results of these audits will be reviewed in QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 01 B. WING	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - ELKHART CARE CENTER	1001 W HIVELY AVE ELKHART, IN 46517

(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
			monthly for 6 months or until 100% compliance is achieve x3 consecutive months. Results of the audits will be adjusted as needed to maintain compliance. **Date of compliance** **9/13/2024**	