CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN			COMPLETED			
		155685	B. WING		08/27/2024	
			<u> </u>		<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD  V HIVELY AVE		
BRICKYA	ARD HEALTHCARE	- ELKHART CARE CENTER	ELKHA	RT, IN 46517		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg			E 0000	The facility and it's managing partners respectfully request t this Plan of Correction be considered for desk review.	hat	
	Brickyard Healthcar found not in compli Preparedness Requi Medicaid Participat CFR 483.73	Preparedness survey, re - Elkhart Care Center was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of				
E 0032 SS=F Bldg	Primary/Alternate  Based on record rev failed to ensure the communication plan alternate means for following: (i) LTC tribal, regional, or leagencies in accorda		E 0032	E 032 What corrective action(s) will I accomplished for those reside found to have been affected by deficient practice? The Facility has an Emergence Preparedness Communication plan in place that includes Pring and alternate means for communicating with Facility st Federal, State, tribal, regional local emergency management	ents by the cy n mary taff, , and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Chad Knisley Executive Director 09/13/2024

Any defiency statement 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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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155685	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/27/2024
	ROVIDER OR SUPPLIER	E - ELKHART CARE CENTER	1001 W	ADDRESS, CITY, STATE, ZIP COD / HIVELY AVE .RT, IN 46517	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Executive Director 9:15 a.m. to 12:47 preparedness common address primary communication. Ba records review, the was not able to locator primary and alto.  This finding was re	view and interview with the and Maintenance Director from p.m. on 08/26/24, the emergency nunication plan provided did v and alternate means for sed on interview at the time of Executive Director stated he atte documentation in the plan ernate means of communication.  Viewed with the Maintenance enance Assistant at the exit		agencies in the event of an emergency. This communicate plan was not presented at the of survey.  How will you identify other residents having the potentiat 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 impact by this deficiency. Education been provided on location and contents of Emergency Preparedness Manuals for all What measures will be put in 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 P The Executive Director/design will ensure the Emergency Communication Plan is review upon hire, monthly with all-staff meetings for 6 months and quarterly thereafter.  How will the corrective action(s) be monitored:  Maintenance Director/designed will report to QAPI no less that quarterly to ensure ongoing quassurance and compliance.	al  cted has d staff. hto  lan. hee red ff
			1	9/13/2024	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	155685	A. BU B. WI		01	COMPLETED 08/27/2024	
				CTREET	ADDRESS SITE STATE SID COD	00/21/	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD  / HIVELY AVE		
BRICKY	ARD HEALTHCARE	- ELKHART CARE CENTER	ELKHART, IN 46517				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
	REGULATORT OR	LISC IDENTIFTING INFORMATION	<u> </u>	TAG			DATE
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w Department of Heal 483.90(a).  Survey Dates: 08/2  Facility Number: 0 Provider Number: AIM Number: 100.  At this Life Safety 0 Healthcare - Elkhar compliance with Re Medicare/Medicaid Life Safety from Fir National Fire Protec Life Safety Code (L Health Care Occupa  This one-story facil Type V (000) consts sprinklered except f maintenance shop. East and South Unit with an addition (Pr built in 1975. The file decommissioned an facility has a fire ala detection in the corr the corridor. The fa smoke detectors in a The facility is prote	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR  6/24 - 08/27/24  00039 155685 275130  Code survey, Brickyard t Care Center was found not in requirements for Participation in requirements for Participation in requirements for Participation of the retion Association (NFPA) 101, re and the 2012 edition of the retion Association (NFPA) 101, resc), Chapter 19, Existing received and 410 IAC 16.2.  The original building (North, res) was constructed in 1968 rimrose and Southwest Units)	K 0		The facility and it's managing partners respectfully request t this Plan of Correction be considered for desk review.	hat	DATE
	The facility has 175	certified beds. At the time of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155685		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  08/27/2024	
	PROVIDER OR SUPPLIER	- ELKHART CARE CENTER		1001 W	DDRESS, CITY, STATE, ZIP COD HIVELY AVE RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	access were sprinkle facility services were exception of the ele shop.  Quality Review consumption of the ele shop.  Quality Review consumption of the ele shop.  Quality Review consumption of the ele shop.  Based on observation failed to ensure the more than 20 exits were residents without a specialized security required means of e with a latch or lock or key from the egrepermitted by LSC 1 arrangements shall with 19.2.2.2.5.2. The affect 45 residents, affect 45 resi	residents have customary ered and all areas providing re sprinklered with the etrical room in the maintenance inpleted on 08/29/24  on and interview, the facility means of egress through 1 of were readily accessible for clinical diagnosis requiring measures. Doors within a gress shall not be equipped that requires the use of a tool ess side unless otherwise 9.2.2.2.4. Door-locking be permitted in accordance this deficient practice could staff and visitors.  on and interview with the facility at 2:40 p.m. on ate from the main courtyard in was magnetically locked at the code was not posted at interview, the Maintenance codes were posted by all other post the code on the arryard gate as well.  viewed with the Maintenance enance Assistant at the exit	K 022	2	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 exit. How will you identify other residents having the potentiat 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 code posted. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director educate posting codes to egress	it of al	09/13/2024

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155685	ľ í	LDING	nstruction 01	(X3) DATE COMPL <b>08/27</b> /	ETED
	PROVIDER OR SUPPLIER	- ELKHART CARE CENTER		1001 W	DDRESS, CITY, STATE, ZIP COD HIVELY AVE RT, IN 46517		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
K 0293	onference. 3.1-19(b)				doors/gates. Preventative Maintenance audit will be adde Building TELS to check egress door/gate codes are posted. How will the corrective action(s) be monitored: Maintenance Director/designed will monitor doors to ensure code are posted daily for 5 days, weekly for 4 weeks and month thereafter as part of their Preventative Maintenance program. Results of these aud will be reviewed in QAPI month for 6 months or until 100% compliance is achieved for 3 consecutive months. Results of audits will be adjusted as need to maintain compliance.  Date of compliance 9/13/2024	e odes ly dits hly	
SS=E Bldg. 01	Exit Signage	on and interview, the facility	K 02	03	K 293		09/13/2024
	failed to ensure 1 of outside of the facility exit. LSC 7 passage, or stairway way of exit access a so that it is likely to be identified by a si EXIT. The NO EX in letters 2 inches h 3/8ths inch, and the NO, unless such sig	f more than 20 doors to the ty were not mistaken as a 1.10.8.3.1 states any door, that is neither an exit nor a and that is located or arranged be mistaken for an exit shall gn that reads as follows: NO IT sign shall have the word NO igh, with a stroke width of word EXIT below the word in is an approved existing practice could affect 24	1 02		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 potentiat to be affected by the same deficient practice and what	n	07/13/202T

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED		
		155685	B. WI	NG		08/27/	/2024
	1	E - ELKHART CARE CENTER STATEMENT OF DEFICIENCIE		1001 W	ADDRESS, CITY, STATE, ZIP COD  / HIVELY AVE  RT, IN 46517  PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	те	COMPLETION DATE
	Maintenance Direct during a tour of the 08/26/24, the South not posted with an A gate in the courty preventing it from the time of the observated he was garden at the door.  This finding was re	on and interview with the tor and Maintenance Assistant facility at 2:11 p.m. on a unit door to the courtyard was EXIT sign or a NO EXIT sign. For ard was secured in a manner opening. Based on interview at ervation, the Maintenance was not aware of missing viewed with the Maintenance enance Assistant at the exit			corrective action will be taken?  Exterior Doors have been assessed to ensure doors that 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 in place or what systemic changes will you make to ensure that the deficient practice does not recur?  Maintenance Director/designer monitor through Preventative Maintenance program in TELS 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/designer will monitor report to QAPI not than quarterly to ensure qualit assurance and compliance.  Date of compliance  9/13/2024	re e ato ace ee ee less	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System	- Installation					
	failed to maintain the front lobbies in accestandard for the Instance NFPA 13, 2010 edited plates, escutcheons cover the annular species of the metallic, or shall be metallic, or shall shall be metallic.	on and interview, the facility the ceiling construction in 1 of 1 tordance with NFPA 13, stallation of Sprinkler Systems. tion, Section 6.2.7.1 states to or other devices used to topace around a sprinkler shall be listed for use around a cient practice could affect	K 0.	351	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 lobb has been repaired to ensure the	<b>n</b> oy	09/13/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155685	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	E SURVEY LETED 7/2024
	PROVIDER OR SUPPLIED	R E - ELKHART CARE CENTER	1001 W	ADDRESS, CITY, STATE, ZIP COD V HIVELY AVE ART, IN 46517		
(X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF residents, staff and compartments.  Findings include:  Based on observati Maintenance Direct during a tour of the a.m. on 08/27/24, an escutcheon that annular space arous approximately one- escutcheon was ope ceiling. Based on in observation, the Maneeded to repair the	E - ELKHART CARE CENTER  STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  visitors in 1 of 8 smoke  on and interview with the tor and Maintenance Assistant e facility from 8:50 a.m. to 10:30 a sprinkler in the front lobby had did not cover the entire and the sprinkler. A space of chalf inch around the en to the space above the drop interview at the time of aintenance Director stated he e area around the sprinkler.  eviewed with the Maintenance tenance Assistant at the exit		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)  devise used to cover the a space around the sprinkle How will you identify oth residents having the pote to be affected by the sam deficient practice and who corrective action will be taken?  A complete audit of sprink heads has been complete ensure the escutcheon and sprinkler head covers the space around the sprinkled What measures will be place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director/des complete a whole house a sprinkler head escutcheor then quarterly thereafter at the Preventative Maintenance program.  How will the corrective action(s) be monitored: Maintenance Director/des one whole house audit of head escutcheon plates the sprinkles of the surface of the surface of the program.	annular r head. er ential ne nat  der d to ound the annular r head. ut into  o  ignee to audit of n plates s part of ance ignee to sprinkler nen	(X5) COMPLETION DATE
				quarterly thereafter as par Preventative Maintenance program. Results of these audits wi reviewed in QAPI. Result audits will be adjusted as to maintain compliance.	ll be s of	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System	- Maintenance and Testing				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED			ĺ ,		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			<u>01</u>	COMPLETED	
		155685	B. W	ING		08/27/2024	
NAME OF D	ROVIDER OR SUPPLIER	}	-		ADDRESS, CITY, STATE, ZIP COD		
					/ HIVELY AVE		
BRICKYA	ARD HEALTHCARE	E - ELKHART CARE CENTER	ELKHART, IN 46517				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		on and interview, the facility	K 0	353	K 353	09/13/2024	
		1 fire department connections			What corrective action(s) wil	ll	
		with NFPA 25, 2011 Edition,			be accomplished for those		
		spection, Testing, and			residents found to have been	n	
	Maintenance of Water-Based Fire Protection				affected by the deficient		
	-	3.7.1 requires fire department			practice?	- 6 41	
	connections to be inspected quarterly to verify the following:  (1) The fire department connections are visible				The bush obscuring the view of	<b> </b>	
					Fire Department Connection (	•	
	and accessible.	ment connections are visible			to the Sprinkler System has be		
		vivels are not damaged and			removed and directional signates has been posted from the mail	-	
	rotate smoothly.	vivers are not damaged and			parking lot to the FDC.		
	_	e in place and undamaged.			How will you identify other		
		lace and in good condition.			residents having the potentia	al le	
	(5) Identification signs are in place.				to be affected by the same	ai	
	(6) The check valve	-			deficient practice and what		
		Irain valve is in place and			corrective action will be		
	operating properly.				taken?		
		nent connection clapper(s) is in			All residents, staff and visitors		
	place and operating				have the potential to be impact		
		ice could affect all residents,			by this deficiency. The bush		
	staff and visitors.				obscuring the view of the Fire		
					Department Connection (FDC	<b> </b>	
	Findings include:				the Sprinkler System has been	n	
					removed and directional signa	age	
		on and interview with the			has been posted from the mai	in	
		tor and Maintenance Assistant			parking lot to the FDC.		
	•	26/24, at the facility's front			What measures will be put ir	nto	
		ire department connection			place or what systemic		
		at the side of the front door			changes will you make to		
		by bush in the landscaping			ensure that the deficient		
		from the main roadway. There			practice does not recur?		
		signage on the property			Maintenance Director/designe		
	-	Based on interview, the			will monitor to ensure exterior		
		tor stated the FDC would not			shubs/trees do not obscure th		
	_	knowledge of the location			view of the FDC from the mair		
		aintenance Director stated he			roadway 5x/week for 4 weeks	and	
	-	the bush and provide			monthly thereafter.		
	directional signage	from the main parking lot.			How will the corrective		
					action(s) be monitored:		

CEI(TEROTOI	THE TOTAL CONTESTS	THE SERVICES			0.012 1101 0,00 00,
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155685	B. WING		08/27/2024
				ADDRESS CITY OF THE STREET	
NAME OF P	PROVIDER OR SUPPLIEF	Ł		ADDRESS, CITY, STATE, ZIP COD	
DDIGIG:	NDD 11E A1 T110 1 = =	FULLIART CARE CENTER		/ HIVELY AVE	
BRICKYA	AKD HEALTHCARE	- ELKHART CARE CENTER	ELKHA	RT, IN 46517	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	This finding was re	viewed with the Maintenance		Audits will be conducted mont	hly
	_	enance Assistant at the exit		based on Preventative	,
	conference.			Maintenance program. Resul	ts of
				these audits will be reviewed i	
	3.1-19(b)			QAPI monthly for 6 months or	until
				100% compliance is achieved	
				consecutive months. Results	
				audits will be adjusted as need	
				to maintain compliance.	
				Date of compliance	
				9/13/2024	
K 0741	NFPA 101				
SS=F	Smoking Regulati	ons			
Bldg. 01					
	Based on record rev	view, observation and	K 0741	K 741	09/13/2024
	interview, the facili	ty failed to provide a smoking		What corrective action(s) wil	ı
	policy, regulations,	or other documentation which		be accomplished for those	
	included any of the	provisions as required by LSC		residents found to have been	n
	Section 19.7.4. This	s deficient practice could affect		affected by the deficient	
	all residents, staff a	nd visitors.		practice?	
				Cigarettes butts have been	
	Findings include:			cleaned from ground in	
				"Designated Smoking Areas"	for
	Based on record rev	view and interview with the		staff and residents. Signage i	s
	Executive Director	and Maintenance Director from		posted designating Smoking	
	9:15 a.m. to 12:47 p	o.m. on 08/26/24, no documented		areas.	
	smoking policy cou	lld be provided. Based on		How will you identify other	
	interview at the tim	e of record review, the		residents having the potentia	al
	Executive Director	and Maintenance Director		to be affected by the same	
	stated the facility ha	as designated smoking areas		deficient practice and what	
	for staff and resider	nts in the rear area of the		corrective action will be	
	building but was no	t able to produce any		taken?	
	documentation stati	ng a policy or facility		All residents, staff and families	s
	regulations regardir	ng smoking. Based on		have the potential to be impact	
		erview with the Maintenance		by this deficiency. Maintenan	<b>I</b>
	Director and Mainte	enance Assistant during a tour		Director/designee will conduct	
		8:50 a.m. to 10:30 a.m. on		audit around building to ensur	

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08/27/24, three smokers poles were provided;

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there are no smoking butts. Any

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155685	B. WING		08/27/2024
	ROVIDER OR SUPPLIER	- ELKHART CARE CENTER	1001 V	ADDRESS, CITY, STATE, ZIP COD V HIVELY AVE ART, IN 46517	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	on the ground outside Southwest unit exitatime of observation, stated they will cleated ground and properly.  This finding was revenue.	en cigarette butts were strewn de the facility near the Based on interview at the the Maintenance Director n up the cigarette butts on the dispose of them.  Viewed with the Maintenance enance Assistant at the exit		defects identified and cleaned immediately.  What measures will be put in 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 Smokin areas and how to dispose of cigarettes. All staff will be re-educated on how to assist residents to ensure cigarettes disposed of properly. Areas a being monitored and any impredisposal of cigarette butts is be addressed immediately.  How will the corrective action(s) be monitored:  Maintenance Director/designe will report to QAPI no less that quarterly to ensure quality assurance and compliance.	are re oper eing
				Date of compliance 9/13/2024	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - <sup>-</sup>	Fransfilling Cylinders			
	failed to ensure staff transfilling oxygen edition, Section 11.3 individual transfilling properly trained in the Section 11.5.2.1.2 section 11.5.2 section 11.5.2 section 11.5.2 section	iew and interview, the facility f were properly trained on procedures. NFPA 99 2012 5.2.3.1 (4) requires the ng the container(s) to be the transfilling procedures. tates: Health care facilities shall f continuing education for tion 11.5.2.1.3 states: on 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 sat and oxygen usage and transfil	n fety

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155685	B. W	ING		08/27/	2024
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			/ HIVELY AVE		
BDICKV	ADD HEALTHCADE	E - ELKHART CARE CENTER			RT, IN 46517		
DICICITY	AND HEALTHCAN	E - ELNIANT CARE CENTER		ELKITA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	^	safety guidelines and usage			to liquid oxygen containers or	to	
	_	edical gases and their			portable containers.		
	_	icient practice could affect all			How will you identify other		
	residents, staff and	visitors.			residents having the potential	al	
					to be affected by the same		
	Findings include:				deficient practice and what		
					corrective action will be		
		view and interview with the			taken?		
		and Maintenance Director from			This deficiency has the potent	ial	
	9:15 a.m. to 12:47 p.m. on 08/26/24, documentation				to affect all residents, staff and	b	
	titled "Oxygen Safety" was provided which				families. All direct care staff h	ave	
	included requirements for continued training;				been educated to ensure they	are	
	however, no documentation of training conducted				properly trained on oxygen sa	-	
	was available to indicate that staff who transfill				and oxygen usage and transfi	lling	
	liquid oxygen was properly trained for transfilling.				to liquid oxygen containers or	to	
		, the Executive Director stated			portable containers.		
		he training documents;			What measures will be put in	ıto	
	however, no docun	nentation was provided.			place or what systemic		
					changes will you make to		
		eviewed with the Maintenance			ensure that the deficient		
		enance Assistant at the exit			practice does not recur?		
	conference.				Staff Development		
					Director/designee will re-inser	vice	
	3.1-19(b)				and complete Competency		
					checks for all direct care staff.		
					Staff Development		
					Director/designee will ensure		
					direct care staff are trained or		
					"Oxygen Safety" and "Oxygen		
					Safety Education Competency	*	
					completed upon hire and during	ng	
					annual Skills Fair.		
					How will the corrective		
					action(s) be monitored:		
					Staff Development		
					Director/designee will audit we	-	
					with new hires for 4 weeks, th		
					monthly to ensure education i	s	
					completed. Results of these		
	l				audits will be reviewed in QAF	וי	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155685	(X2) MULTIPLE C A. BUILDING B. WING STREET	ONSTRUCTION  01  ADDRESS, CITY, STATE, ZIP COD	(X3) DATE COMPI <b>08/27</b> ,	LETED	
BRICKYARD HEALTHCARE - ELKHART CARE CENTER  (Y4) ID SUMMARY STATEMENT OF DEFICIENCIE			1001 W HIVELY AVE ELKHART, IN 46517				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
				monthly for 6 months or until 100% compliance is achieve x consecutive months. Results the audits will be adjusted as needed to maintain compliance	of		
				Date of compliance 9/13/2024			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8E7T21 Facility ID: 000039 If continuation sheet Page 12 of 12