| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155686 | A. BUILDING -- B. WING | 04/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| BRICKYARD HEALTHCARE - KNOX CARE CENTER | 300 E CULVER RD KNOX, IN 46534 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 04/23/25<br><br>Facility Number: 000088<br>Provider Number: 155686<br>AIM Number: 100289260<br><br>At this Emergency Preparedness survey, Brickyard Healthcare - Knox Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 57 certified beds. At the time of the survey, the census was 48.<br><br>Quality Review completed on 04/25/25 | E 0000 | Preparation, submission and¿ implementation of this Plan of¿ Correction is prepared and¿ executed ¿ continually improve the quality of¿ care and to comply with all¿ applicable state and federal¿ regulatory requirements. Please¿ consider allowing the submission¿ of living center audits and¿ education as evidence of¿ compliance with the state and¿ federal requirements identified in¿ the survey. Respectfully¿ Submitted, Jerrell Harville, HFA¿ | |
| K 0000<br><br>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).<br><br>Survey Date: 04/23/25<br><br>Facility Number: 000088<br>Provider Number: 155686<br>AIM Number: 100289260<br><br>At this Life Safety Code survey, Brickyard | K 0000 | Preparation, submission and¿ implementation of this Plan of¿ Correction is prepared and¿ executed ¿ continually improve the quality of¿ care and to comply with all¿ applicable state and federal¿ regulatory requirements. Please¿ consider allowing the submission¿ of living center audits and¿ education as evidence of¿ compliance with the state and¿ federal requirements | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jerrell Harville | Executive Director | 04/30/2025 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | Healthcare - Knox 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.<br><br>This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a monitored fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms contained battery-operated smoke detectors. The facility has a capacity of 57 and had a census of 48 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review completed on 04/25/25 | | identified in¿ the survey.<br>Respectfully¿ Submitted, Jerrell Harville, HFA¿ | |
| K 0100<br>SS=E<br>Bldg. 01 | NFPA 101<br>General Requirements - Other<br><br>Based on observation and interview, the facility failed to ensure 1 of 1 water heater closets were free and clear of hazards. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect over 10 residents, staff, and visitors.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director, | K 0100 | K100 –General Requirements<br>1. Corrective Action for Residents Affected:<br>No Residents were specifically identified as being affected by this alleged deficiency. Area containing gas fired water heaters were identified, and area was reconfigured, materials identified as potential hazards were removed.<br>2. 10 residents were potentially affected by this alleged | 05/09/2025 |

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| | on 04/23/25 at 2:05 p.m., the water heater closet contained a 2 Gas fired water heaters. Storage in the aforementioned closet included boxes and combustibles up against the gas fired appliances. The MD stated that an outside vendor had placed the boxes in the room next to the gas fired water heaters.<br><br>This finding was acknowledged at the time of observation by the MD and again at the exit conference with the MD, Administrator present.<br><br>3.1-19(b) | | deficiency. Areas containing gas fired water heaters were identified, and area was reconfigured, materials identified as potential hazards were removed.<br>3. Maintenance director will audit areas identified weekly x 4 weeks to ensure they are free from hazards. Any deficiencies will be addressed upon discovery.<br>4. Maintenance director will audit fire doors weekly x 4 weeks, then at least monthly x 6 months with results reported to QAPI.<br>5. Date of Completion will be 5/9/2025. | |
| K 0226 SS=E Bldg. 01 | NFPA 101<br>Horizontal Exits<br><br>Based on observation and interview, the facility failed to ensure 2 of 4 fire door sets were arranged to minimize air leakage. LSC 7.2.4.3.9 requires all fire door assemblies in horizontal exit shall be designed and installed to minimize air leakage. This deficient could affect 24 residents.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director, on 04/23/25 the following fire door sets had at least a 1/2-inch gap along the center where the doors came together in the closed position.<br>a) at 1:40 p.m. the double doors on the west hall.<br>b) at 2:30 p.m. the double door set in the service hall.<br>This condition did not minimize air leakage. Based on interview at the time of observation, the MD agreed that the doors when closed, had a ½ inch | K 0226 | 1 **K226 Horizontal Exits**<br>1 1. No Residents were specifically identified as being affected by this alleged deficiency. Fire doors that were identified as having more than ½ inch gap in center when closed, were modified to meet requirements and eliminating identified gap.<br><br>2 2. 24 residents were potentially affected by this alleged deficiency. All fire doors were inspected to ensure compliance in relation to as having more than ½ inch gap in center when closed.<br><br>3 3. Maintenance director will audit fire doors weekly x 4 weeks to ensure compliance is | 05/09/2025 |

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| | or more gap and confirmed these doors were located within a horizontal exit.<br><br>This finding was acknowledged at the time of observation by the MD and again at the exit conference with the MD, Administrator present.<br><br>3.1-19(b) | | maintained. Any identified issues will be addressed upon discovery.<br><br>4 4. Maintenance director will audit fire doors weekly x 4 weeks, then at least monthly x 6 months with results reported to QAPI.<br><br>5 5. Date of Completion will be 5/9/2025. | |
| K 0321 SS=E Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, as well as staff and visitors near the medical records office.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director, on 04/23/25 at 1:30 p.m., the Medical Records Office area, greater than 50 square feet, contained a number of combustible items, such as, paper, plastic, and over 10 cardboard boxes. The corridor door to this office did not self-close and latch into the door frame. The MD stated that the door would need to have a self-closing device installed.<br><br>This finding was acknowledged at the time of observation by the MD and again at the exit conference with the MD, Administrator present.<br><br>3.1-19(b) | K 0321 | K321 Hazardous Areas Enclosure<br><br>1 1. No residents were specifically identified as being affected by this alleged deficiency. Medial records off was identified as an area over 50 square that contained combustible materials, but did not have a door closure mechanism in place.<br>2 2. No residents were identified as being potentially affected by this alleged deficiency. A door closure mechanism was applied to the identified door.<br>3 3. Maintenance director will audit facility weekly x 4 weeks to identify hazardous areas that require enclosure. Any area identified will be addressed when identified.<br>4 4. Maintenance director will audit facility weekly x 4 weeks, then monthly x 6 months to ensure continued compliance.<br>5 5. Date of Completion will be | 05/09/2025 |

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| | | | 5/9/2025. | |
| K 0511 SS=D Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br><br>Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 storage closet according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect one staff.<br><br>Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director, on 04/23/25 at 2:20 p.m., in the service hall storage closet the outlet cover was missing. Based on interview at the time of observation, the Maintenance Director agreed the outlet was not covered and the faceplate would need to be installed.<br><br>This finding was acknowledged at the time of observation by the MD and again at the exit conference with the MD, Administrator present.<br><br>3.1-19(b) | K 0511 | K511 Gas and Electric Outlet Cover<br><br>1 1. No residents were identified as being affected by this alleged deficiency. One outlet was identified as not having a face cover. A face cover was applied to the identified outlet.<br>2 2. No residents were specifically identified as being potentially affected by this alleged deficiency. The identified outlet was fixed to meet regulatory standard.<br>3 3. Maintenance director will audit facility weekly x 4 weeks, and then monthly x 6 months to ensure compliance is maintained. Any deficiencies that are identified will be addressed upon discovery.<br>4 4. Maintenance director will audit facility weekly x 4 weeks, then monthly x 6 months to ensure continued compliance.<br>5 5. Date of Completion will be 5/9/2025. | 05/09/2025 |
| K 0741 SS=E Bldg. 01 | NFPA 101<br>Smoking Regulations<br><br>Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies. This deficient practice could affect staff around the service exit. | K 0741 | K741 Smoking Regulations<br><br>1 1. No residents were identified as being affected by this | 05/09/2025 |

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| | Findings include:<br><br>Based on observations and interview during a tour of the facility with the Maintenance Director, on 04/23/25 at 2:15 p.m., smoking on the property, not in the designated smoking area, was evident by two employees sitting in chairs, smoking, near the service hall exit in the rear of the facility. The MD stated that the observed employees were not smoking in the designated smoking area which is in the front of the facility.<br><br>This finding was acknowledged at the time of observation by the MD and again at the exit conference with the MD, Administrator present.<br><br>3.1-19(b) | | alleged deficiency. Smoking policy was reviewed and modified to ensure compliance with regulations.<br>2 2. No residents were identified as being potentially affected by this alleged deficiency. The smoking policy was modified to add an area on the southeast corner of the facility for employees to smoke.<br>3 3. Maintenance director provided area with a fire extinguisher, a fire rated receptacle to extinguish smoking materials. Maintenance will audit weekly x 4 weeks and monthly times 6 months to ensure continued compliance.<br>4 4. Maintenance director will audit facility weekly x 4 weeks, then monthly x 6 months to ensure continued compliance.<br>5 5. Date of Completion will be 5/9/2025. | |